Maryland Hospital Community Benefit Report: FY 2016

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

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LIST OF ABREVIATIONS

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

INTRODUCTION

Community benefit refers to initiatives, activities, and investments undertaken by tax-exempt hospitals to improve the health of the communities they serve. Maryland law defines community benefit as an activity that is intended to address community needs and priorities primarily through disease prevention and improvement of health status. Activities can include:

- Health services provided to vulnerable or underserved populations such as Medicaid, Medicare, or Maryland Children's Health Program enrollees
- Financial or in-kind support of public health programs
- Donations of funds, property, or other resources that contribute to a community priority
- Health care cost containment activities
- Health education, screening, and prevention services
- Financial or in-kind support of the Maryland Behavioral Health Crisis Response System[1]

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

This summary report provides background information on hospital community benefits and the history of CBRs in Maryland. It is followed by summaries of the community benefit narrative and financial reports for fiscal year (FY) 2016 and concludes with a summary of data reports from the past 13 years.

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

BACKGROUND

Section 501(c)(3) of the Internal Revenue Code (IRC) identifies tax-exempt, organizations as those that are organized and operated exclusively for specific purposes, including religious, charitable, scientific, and educational purposes.[4] Nonprofit hospitals receive many benefits from their tax-exempt status. They are generally exempted from federal income and unemployment taxes, as well as state and local income, property, and sales taxes. In addition, they are allowed to raise funds through tax-deductible donations and tax-exempt bond financing.

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

In March 2010, Congress passed the Affordable Care Act (ACA).[7] Section 9007 of the ACA established IRC §501(r), which created additional requirements for hospitals to maintain tax-exempt status. Every §501(c)(3) hospital, whether independent or part of a hospital system, must conduct a community health needs assessment (CHNA) at least once every three years in order to maintain its tax-exempt status and avoid an annual penalty of up to $50,000.[8] The first CHNA was due by the end of FY 2013. Assessments must incorporate input from individuals who represent the broad interests of the communities served, including those with special knowledge or expertise in public health, and they must be made widely available to the public.[9] CHNAs must include an implementation strategy that describes how the hospital plans to meet the community's health needs, as well as a description of what the hospital has historically done to address its community's needs.[10] Further, the hospital must identify any needs that have not been met by the hospital and explain why they have not been addressed. Tax-exempt hospitals must report this information on Schedule H of IRS Form 990.

The IRS defines a CHNA as a written document developed for a hospital facility that includes a description of the community served by the hospital facility; the process used to conduct the assessment, including how the hospital took into account input from community members and public health experts; identification of any persons with whom the hospital has worked on the assessment; and the health needs identified through the assessment process. In order to meet the requirement of the CHNA for any taxable year, the hospital facility must make the CHNA widely available to the public and adopt an implementation strategy to meet the health needs

[4] 26 U.S.C. §501(c)(3).
[5] Rev. Ruling 56-185, 1956-1 C.B. 202.
[6] Rev. Ruling 69-545, 1969-2 C.B. 117.
[7] The Patient Protection and Affordable Care Act, P.L. 111-148 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152.
[8] 26 U.S.C. §501(r)(3); 26 U.S.C. §4959.
[9] 26 U.S.C. §501(r)(3)(B).
[10] 26 U.S.C. §501(r)(3)(A).

identified by the CHNA by the end of the same taxable year. The implementation strategy must be approved by an authorized governing body of the hospital organization and either describe how the hospital facility plans to meet the health need(s) identified in the CHNA or explain why it does not intend to meet the health need(s) identified in the CHNA.

The Maryland CBR process was adopted by the Maryland General Assembly in 2001,[11] and the first data collection period was FY 2004. Under Maryland law, CBRs must include a list of the hospital's initiatives, the cost of each community benefit initiative, the objectives of each community benefit initiative, a description of efforts taken to evaluate the effectiveness of initiatives, a description of gaps in the availability of specialist providers, and a description of the hospital's efforts to track and reduce health disparities in the community.[12]

The HSCRC worked with the Maryland Hospital Association (MHA), interested hospitals, local health departments, and health policy organizations and associations to establish the details and format of the CBR. In developing the format for data collection, the group relied heavily on the experience of the Voluntary Hospitals of America (VHA) community benefit process. At the time, the VHA possessed more than ten years of voluntary hospital community benefit reporting experience across many states. The resulting data reporting spreadsheet and instructions were used by Maryland hospitals to submit their FY 2004 data to the HSCRC in January 2005. The HSCRC's first CBR was published in July 2005. The HSCRC continues to work with the MHA, public health officials, individual hospitals, and other stakeholders to further improve the reporting process and refine the definitions and periodically convenes a Community Benefit Work Group. The data collection process offers an opportunity for each Maryland nonprofit hospital to critically review and report the activities it has designed to benefit the community. This FY 2016 report represents the HSCRC's twelfth year of reporting on Maryland hospital community benefit data.

NARRATIVE REPORTS

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

Hospitals Submitting Reports

The HSCRC received a total of 49 CBRs from all 52 hospitals in FY 2016. Please note that the University of Maryland Health System submits a single CBR for three of its hospitals. This CBR sometimes breaks out individual metrics for each of the three hospitals and sometimes combines responses. Therefore, the denominator for hospital response rates varies between 49 and 52 throughout the remainder of this document. Table 1 summarizes the hospitals submitting CBRs by hospital system.

[11] MD. CODE. ANN., Health-Gen. §19-303.
[12] MD. CODE. ANN., Health-Gen. §19-303(a)(3).

Table 1. List of Hospitals Submitting CBRs in FY 2016, by System

Independent Hospitals	**Johns Hopkins Medicine:**
1. Anne Arundel Medical Center	27. Howard County General Hospital
2. Atlantic General Hospital	28. Johns Hopkins Bayview Medical Center
3. Bon Secours Hospital	29. Johns Hopkins Hospital
4. Calvert Memorial Hospital	30. Suburban Hospital
5. Doctors Community Hospital	**Lifebridge Health:**
6. Fort Washington Medical Center	31. Carroll Hospital Center
7. Frederick Memorial Hospital 8. Garrett Regional Medical Center	32. Levindale Hebrew Geriatric Center and Hospital
9. Greater Baltimore Medical Center	33. Northwest Hospital
10. McCready Health	34. Sinai Hospital
11. Mercy Medical Center	**MedStar Health:**
12. Meritus Health	35. MedStar Franklin Square Medical Center
13. Mt. Washington Pediatric Hospital	36. MedStar Good Samaritan Hospital
14. Peninsula Regional Medical Center	37. MedStar Harbor Hospital
15. Saint Agnes Hospital	38. MedStar Montgomery Medical Center
16. Sheppard Pratt Health System 17. Union Hospital	39. MedStar Southern Maryland Hospital Center
18. Western Maryland Regional Medical Center	40. MedStar St. Mary's Hospital
Adventist HealthCare:	41. MedStar Union Memorial Hospital
19. Adventist Behavioral Health	**University of Maryland:**
20. Adventist Healthcare Rehabilitation	42. Baltimore Washington Medical Center
21. Adventist HealthCare Shady Grove	43. Charles Regional Medical Center
22. Washington Adventist Hospital	44. Shore Regional Health[13]
Dimensions Healthcare System:	45. St. Joseph Medical Center
23. Laurel Regional Hospital	46. UMMC Midtown Campus
24. Prince George's Hospital Center	47. University of Maryland Medical Center
Holy Cross Health: 25. Holy Cross Germantown Hospital	48. University of Maryland Rehabilitation & Orthodpaedic Institute
26. Holy Cross Hospital	49. Upper Chesapeake Health[14]

Section I. General Hospital Demographics and Characteristics

Hospital-Specific Demographics

The first section of the CBR narrative requires hospitals to report on demographic and utilization statistics, as summarized in Table 2 below. Overall, the hospitals reported having 11,803 beds and 617,865 inpatient admissions. One hospital misinterpreted the bed designation question and did not report the actual number of beds, thus appearing as missing on the table. The reported percentage of hospital patients who are uninsured ranged from a low of 0.0 to 26.5 percent. The reported percentage of patients enrolled in Medicaid ranged from 6.2 to 79.1 percent. The reported percentage of patients enrolled in Medicare ranged from 10.8 to 78.6 percent. Please

[13] One report includes three facility locations: Easton, Chestertown, and Dorchester.
[14] One report includes two facility locations: Harford Memorial Hospital and Upper Chesapeake Medical Center.

note that some of the figures reported by the hospitals differ from those published by other sources.

Table 2. Hospital Bed Designation, Inpatient Admissions, and Patient Insurance Status, FY 2016

Hospital Name	Bed Designation	Inpatient Admissions	Percentage of Patients who are Uninsured	Percentage of Patients in Medicaid	Percentage of Patients in Medicare
Independent Hospitals					
Anne Arundel Medical Center	415	26,074	**	14.4%	42.6%
Atlantic General Hospital	48	3,360	**	77.1%	71.8%
Bon Secours Hospital	152	3,940	5.5%	41.2%	24.8%
Calvert Memorial Hospital	130	6,207	1.8%	16.2%	36.8%
Doctors Community Hospital	183	9,725	20.0%	16.0%	42.6%
Fort Washington Medical Center	34	2,172	15.4%	24.4%	37.2%
Frederick Memorial Hospital	233	17,714	1.7%	20.0%	34.8%
Garrett Regional Medical Center	47	2,353	1.3%	25.8%	44.5%
Greater Baltimore Medical Center	345	20,552	1.7%	11.2%	32.6%
McCready Health	4	288	14.0%	24.8%	42.4%
Mercy Medical Center	184	13,680	**	19.0%	26.6%
Meritus Health	329	19,825	5.3%	27.3%	31.2%
Mt. Washington Pediatric Hospital	102	830	0.0%	79.1%	Did not provide
Peninsula Regional Medical Center	320	19,015	3.4%	**	**
Saint Agnes Hospital	251	18,354	**	**	**
Sheppard Pratt Health System	Did not provide	9,147	3.2%	39.9%	18.0%
Union Hospital	118	5,674	1.9%	23.1%	57.3%
Western Maryland Regional Medical Center	208	12,899	13.8%	19.7%	53.9%
Adventist HealthCare					
Adventist Behavioral Health	107	2,649	2.5%	32.1%	14.3%
Adventist Healthcare Rehabilitation	87	1,943	0.7%	8.3%	53.4%
Adventist HealthCare Shady Grove	305	21,212	7.0%	21.5%	18.0%
Washington Adventist Hospital	232	12,211	16.5%	27.9%	21.8%
Dimensions Healthcare System					
Laurel Regional Hospital	134	4,147	12.0%	22.4%	Did not provide
Prince Georges Hospital Center	237	14,315	19.0%	33.0%	Did not provide
Holy Cross Health					
Holy Cross Germantown Hospital	118	5,240	21.6%	23.6%	14.8%
Holy Cross Hospital	582	35,206	26.5%	23.0%	17.8%

Hospital Name	Bed Designation	Inpatient Admissions	Percentage of Patients who are Uninsured	Percentage of Patients in Medicaid	Percentage of Patients in Medicare
Johns Hopkins Medicine					
Howard County General Hospital	264	17,431	**	**	**
Johns Hopkins Bayview Medical Center	447	20,273	**	**	**
Johns Hopkins Hospital	1,129	48,554	**	**	**
Suburban Hospital	236	13,265	**	7.4%	48.6%
Lifebridge Health					
Carroll Hospital Center	140	10,002	5.3%	15.3%	29.9%
Levindale Hebrew Geriatric Center and Hospital	330	2,397	5.0%	11.0%	74.0%
Northwest Hospital	238	11,610	0.5%	20.0%	51.1%
Sinai Hospital	505	12,823	0.5%	28.3%	42.6%
MedStar Health					
MedStar Franklin Square Medical Center	364	23,525	1.4%	32.0%	40.8%
MedStar Good Samaritan Hospital	246	9,580	**	6.2%	33.3%
MedStar Harbor Hospital	157	11,488	1.6%	40.9%	35.1%
MedStar Montgomery Medical Center	122	7,815	6.0%	19.3%	27.7%
MedStar Southern Maryland Hospital Center	256	12,148	**	**	**
MedStar St. Mary's Hospital	91	8,972	3.5%	12.3%	36.8%
MedStar Union Memorial Hospital	209	11,383	**	**	**
University of Maryland					
Baltimore Washington Medical Center	303	18,512	1.0%	17.9%	53.4%
Charles Regional Medical Center	115	7,610	6.1%	22.5%	41.9%
Shore Regional Health Easton	112	8,262	0.5%	23.2%	54.7%
Shore Regional Health Chestertown	30	1,531	0.9%	12.1%	78.6%
Shore Regional Health Dorchester	47	2,214	0.8%	25.7%	61.4%
St. Joseph Medical Center	247	17,821	1.6%	46.0%	10.8%
UMMC Midtown Campus	167	4,572	1.0%	47.0%	44.0%
University of Maryland Medical Center	750	28,864	1.0%	37.0%	32.0%
University of Maryland Rehabilitation & Orthodpaedic Institute	138	2,617	1.0%	21.0%	41.0%
Harford Memorial Hospital	85	4,384	1.8%	14.2%	39.4%
Upper Chesapeake Medical Center	170	11,480	1.8%	14.2%	39.4%
Total	**11,803**	**617,865**			

**Hospital supplied this data by county rather than as a percentage of their entire patient population.

Service Areas

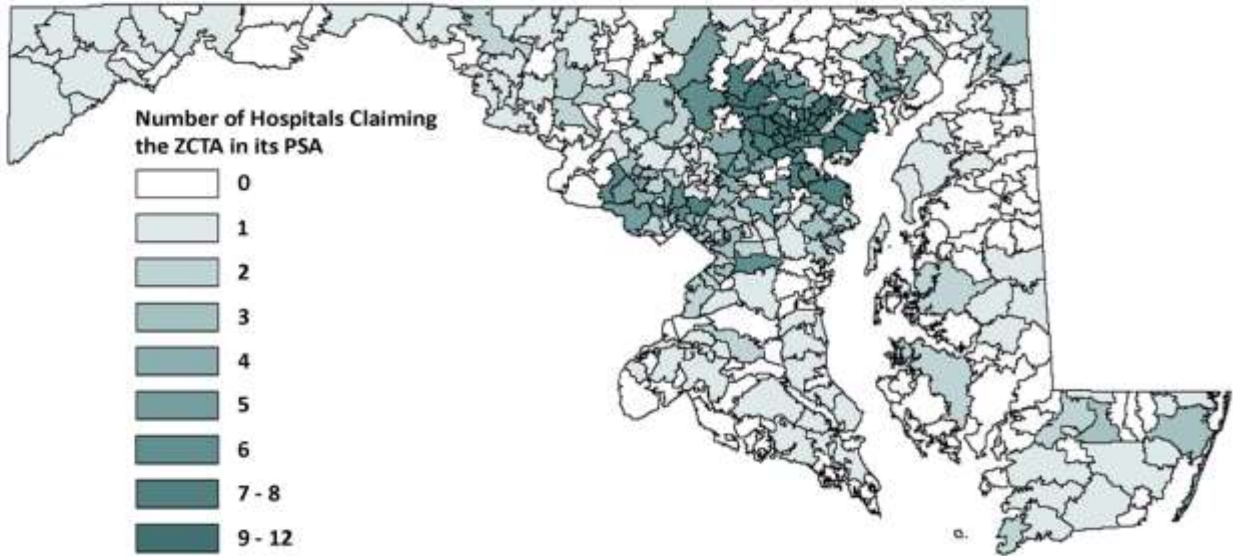
The CBR requires hospitals to report on two types of services area: (1) the primary service area (PSA), and (2) the community benefit service area (CBSA). It is important to note that the CBR

PSAs reported by the hospitals may not align with the PSAs used by the HSCRC for global budgeting purposes.

Primary Service Area

The CBR collects the ZIP codes included in each hospital's reported PSA, and all hospitals responded to this question. Figure 1 displays a map of Maryland split into ZIP Code Tabulation Areas (ZCTAs)[15]. Each ZCTA has a color indicating how many hospitals claim that area in its CBR PSA. A total of 280 ZCTAs, those that appear white on the map, are not covered by any hospital. A total of 13 ZCTAs are covered by 9 or more hospitals.

Figure 1. Number of Hospitals Claiming the ZCTA in its CBR PSA, FY 2016



Community Benefit Service Area

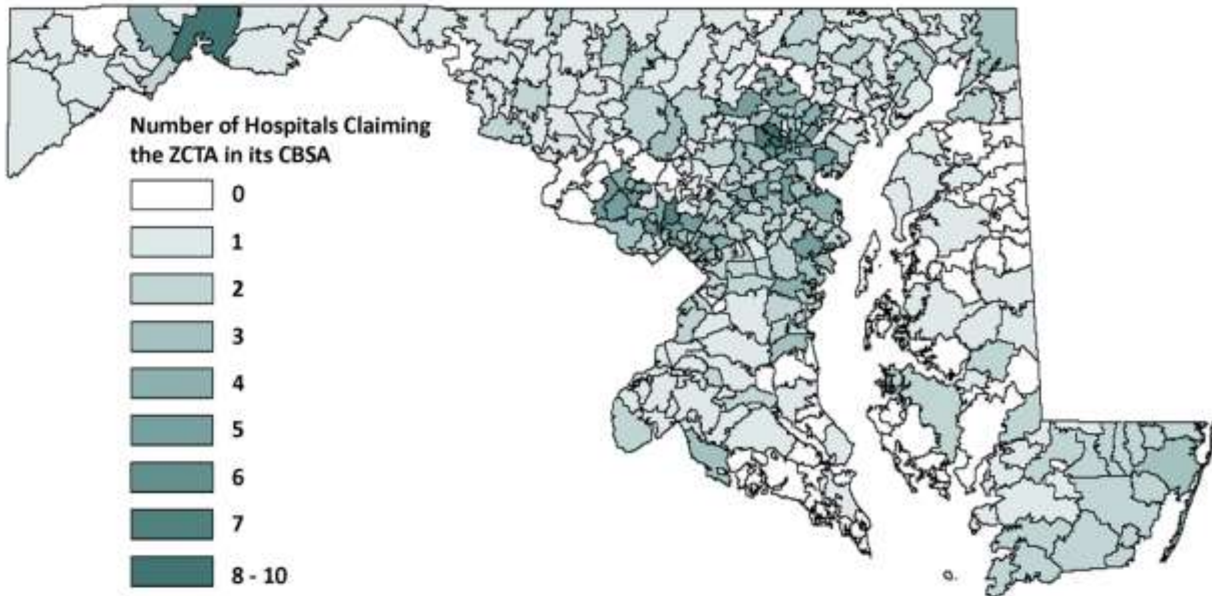
The CBR also collects the ZIP codes included in each hospital's CBSA, and all hospitals responded to this question. Each hospital defines its own CBSA and must disclose the methodology behind this definition in both their CBRs and their federally-mandated CHNAs[16]. While the methodology for determining the CBSA varied, many hospitals reported using measures of social determinants of health and health disparities, such as below average median family income, above average rates of unemployment, racial/ethnic disparities in infant mortality, and racial/ethnic disparities in diabetes mortality. Other methodologies examined utilization measures, such as areas with high emergency department utilization.

Figure 2 displays a map of Maryland split into ZCTAs. Each ZCTA has a color indicating how many hospitals claim that area in its CBSA. One hospital reports its CBSA at the Community

[15] The U.S. Census Bureau created ZCTAs based on ZIP codes for mapping purposes: https://www.census.gov/geo/reference/zctas.html.
[16] 26 CFR § 1.501(r)-3.

Statistical Area-level. For purposes of creating the map below, these were converted to ZCTAs. A total of 186 ZCTAs, those that appear white on the map, are not a part of any hospital's CBSA, and a total of 3 ZCTAs in Baltimore City are covered by eight or more hospitals. See Appendix A for lists of these ZIP codes.

Figure 2. Number of Hospitals Claiming the ZCTA in its CBSA, FY 2016



Other Demographic Characteristics of Service Areas

Hospitals are required to submit details about the communities in their CBSA. Because most of the required measures in this section of the report are not available at the ZIP code level, they are reported at the county level instead. Table 3 displays examples of the county-level demographic measures required in the CBR. Because hospitals varied in their approaches and completeness in providing the metrics for this section of the report, the data in Table 3 were retrieved independently. See Appendix B for other community health measures reported by the hospitals.

The following measures were prepared using the five-year (2011-2015) average estimates from the U.S. Census Bureau's American Community Survey: median household income, percentage of families below the federal poverty level (FPL), percentage uninsured, percentage of the civilian non-institutionalized population with public health insurance, mean travel time to work, percentage that speak a language other than English at home, percentage that speak a language other than English at home and speak English less than "very well," percentage by race categories, and percentage by ethnicity categories. The life expectancy three-year average (2013-2015) and the crude death rate (2015) measures are from the Maryland Department of Health and Mental Hygiene's Vital Statistics Administration.

Table 3. 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		**74,551**	**7.0**	**9.0**	**28.8**	**26.4**	**32.3**	**17.2**	**60.0**	**31.2**	**9.0**	**79.7**	**786.4**
Allegany	1	40,551	11.7	7.3	43.6	32.6	20.7	4.8	90.3	9.4	1.6	76.9	1300.2
Anne Arundel	7	89,860	3.8	6.4	25.1	18.7	29.7	10.5	77.7	17.6	6.9	79.8	725.8
Baltimore	9	67,095	6.3	8.1	29.7	26.1	29.1	13.6	65.4	28.6	4.8	79.1	978.7
Baltimore City	15	42,241	19.0	10.3	43.9	48.1	30.5	8.9	32.0	64.4	4.6	73.9	1037.7
Calvert	1	95,828	3.5	6.1	24.3	18.8	40.1	4.3	85.1	14.5	3.3	80.1	724.1
Caroline	1	52,465	12.3	11.3	41.2	39.4	32.9	6.5	83.4	15.2	6.1	76.1	1009.9
Carroll	2	85,385	3.4	4.7	23.9	15.7	35.2	5.2	94.3	4.2	2.9	79.3	904.4
Cecil	1	66,396	6.8	7.9	30.4	29.2	28.8	5.0	90.7	7.8	3.9	77.1	929.9
Charles	2	90,607	6.0	5.3	24.3	23.1	42.8	7.3	51.5	45.5	5.0	79.5	634.1
Dorchester	1	47,093	11.9	8.5	45.6	43.4	24.8	5.5	68.9	29.1	4.3	77.6	1222.8
Frederick	3	83,700	4.7	6.8	23.2	18.7	34.9	12.6	84.0	10.6	8.1	80.8	715.8
Garrett	1	45,432	9.6	10.7	41.4	32.5	23.7	3.4	98.6	1.4	0.9	78.8	1133.7
Harford	2	80,465	6.2	5.0	26.9	19.5	31.7	6.7	82.2	14.6	4.0	79.7	826.2
Howard	5	110,238	3.8	6.0	19.3	16.5	30.5	23.0	63.0	20.0	6.3	82.9	527.4
Kent	1	58,147	6.4	7.9	42.6	28.3	25.6	5.5	83.2	16.0	4.3	79.5	1248.3
Montgomery	9	99,435	4.6	10.3	23.0	21.0	34.5	39.6	58.9	19.3	18.3	84.6	573.2
Prince George's	10	74,260	6.9	13.8	27.3	29.4	36.5	22.5	22.2	65.2	16.2	79.9	630.0
Queen Anne's	1	85,963	5.2	5.1	28.8	20.3	34.7	4.7	90.6	8.1	3.4	79.6	799.5
Saint Mary's	1	86,987	6.1	6.4	25.2	23.1	29.3	7.4	81.9	15.9	4.5	79.1	709.1
Somerset	2	35,154	20.3	10.6	46.8	36.4	24.1	7.5	55.0	43.4	3.6	76.3	958.6
Talbot	1	58,228	7.8	9.7	40.1	24.6	26.0	7.8	85.6	12.8	6.0	80.8	1228.9

County	# of Hospitals w/ CBSAs in that County	Median Household Income	% Below FPL	% Uninsured	% Public Health Insurance	% Medicaid	Mean Travel Time to Work (mins)	% Speak Language Other than English at Home	Race: % White	Race: % Black	Ethnicity: % Hispanic or Latino	Life Expectancy	Crude Death Rate (per 100,000)
Washington	1	56,228	9.7	8.4	36.3	31.7	28.4	7.0	86.8	12.7	4.0	77.4	1015.5
Wicomico	2	52,278	11.1	10.0	35.2	36.9	21.3	10.6	71.3	26.2	4.9	77.4	885.0
Worcester	2	56,773	7.6	9.5	43.6	29.2	23.4	5.9	83.7	14.8	3.3	79.4	1263.1
Source	17	18	19	20	21	22	23	24	25	26	27	28	29

[17] As reported by hospitals in their FY 2016 Community Benefit Narrative Reports
[18] American Community Survey 5-Year Estimates 2011 – 2015, Selected Economic Characteristics, Median Household Income (Dollars), https://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t
[19] American Community Survey 5-Year Estimates 2011 – 2015, Selected Economic Characteristics, Percentage of Families and People Whose Income in the Past 12 Months is Below the Federal Poverty Level – All Families
[20] American Community Survey 5-Year Estimates 2011 – 2015, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – No Health Insurance Coverage
[21] American Community Survey 5-Year Estimates 2011 – 2015, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – With Public Coverage
[22] American Community Survey 5-Year Estimates, 2011-2015 (denominator) and The Hilltop Institute (numerator)
[23] American Community Survey 5-Year Estimates 2011 – 2015, Selected Economic Characteristics, Commuting to Work – Mean Travel Time to Work (Minutes)
[24] American Community Survey 5-Year Estimates 2011 – 2015, Language Spoken at Home, Speak a Language Other Than English
[25] American Community Survey 5-Year Estimates 2011 – 2015, ACS Demographic and Housing Estimates, Race - Race alone or in combination with one or more other races - Total Population - White
[26] American Community Survey 5-Year Estimates 2011 – 2015, ACS Demographic and Housing Estimates, Race - Race alone or in combination with one or more other races - Total Population – Black or African American
[27] American Community Survey 5-Year Estimates 2011 – 2015, ACS Demographic and Housing Estimates, Hispanic or Latino and race - Total Population - Hispanic or Latino (of any race)
[28] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2015, Table 7. Life Expectancy at Birth by Race, Region, and Political Subdivision, Maryland, 2013 – 2015.
[29] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2015, Table 39A. Crude Death Rates by Race, Hispanic Origin, Region, and Political Subdivision, Maryland, 2015.

Section II. Community Health Needs Assessment

Section II of the narrative CBR asks hospitals whether they conducted a CHNA, when they last conducted it, and whether they adopted an implementation strategy. All hospitals reported conducting a CHNA that conforms to the IRS definition within the past three fiscal years. All but one hospital reported adopting an implementation strategy. See Appendix B for the dates in which hospitals conducted their last CHNAs. These dates ranged from March 2013 to December 2016.

Section III. Community Benefit Administration

This section of the narrative CBR requires hospitals to report on the process of "determining which needs in the community would be addressed through community benefits activities." Hospitals must provide details of the planning, staffing, and oversight of their community benefit efforts.

Community Benefit Planning in Strategic Plan

This section of the CBR asks hospitals about the involvement of community benefit in strategic planning. Two hospitals provided an incomplete response to this question. All but one hospital indicated that their strategic plan includes community benefit considerations. Hospital narrative responses often mentioned that community benefit strengthens the hospital's culture and capabilities, and thereby strengthening community ties. For example, one hospital wrote that they "fully integrate [their] commitment to community service into [their] management and governance structures as well as strategic and operational plans." The community benefit plan is closely aligned with the hospital's population health management plan.

Stakeholders

This section of the CBR asks hospitals to indicate the stakeholders involved in the implementation and delivery of community benefit activities. Table 4 summarizes responses to this question across all 49 hospitals. The most common staff member involved in community benefit activities is the chief executive officer, reported by 46 of the 49 hospitals. The least common community benefit stakeholder across hospitals, with 10 out of 49, is a Community Benefit Task Force.

Table 4. Hospital Stakeholders Involved in Community Benefit Process

	Number of Hospitals		
Stakeholders	**Yes**	**No**	**Did not Provide**
Senior Leadership			
CEO	46 (93.9%)	2 (4.1%)	1 (2.0%)
CFO	42 (85.7%)	6 (12.2%)	1 (2.0%)
Other	43 (87.8%)	6 (12.2%)	0 (0.0%)
Clinical Leadership			
Physician	44 (89.8%)	4 (8.2%)	1 (2.0%)
Nurse	44 (89.8%)	4 (8.2%)	1 (2.0%)
Social Worker	19 (38.8%)	29 (59.2%)	1 (2.0%)
Other	24 (49.0%)	25 (51.0%)	0 (0.0%)
Population Health Leadership and Staff			
Population Health VP or Equivalent	29 (59.2%)	15 (30.6%)	5 (10.2%)
Other Population Health Staff	30 (61.2%)	13 (26.5%)	6 (12.2%)
Community Benefit Operations			
Individual	31 (63.3%)	17 (34.7%)	1 (2.0%)
Committee	27 (55.1%)	21 (42.9%)	1 (2.0%)
Department	24 (49.0%)	23 (46.9%)	2 (4.1%)
Task Force	10 (20.4%)	36 (73.5%)	3 (6.1%)
Other	20 (40.8%)	28 (57.1%)	1 (2.0%)

Senior leadership provided varying roles in the community benefit process. In general, most hospitals indicated that senior leadership had a role in defining the organization's population health objectives and creating the infrastructure that delivers health services to targeted populations. Some hospitals reported that senior leadership plays an active role in community benefit activities through a structured committee process with formal, regular meetings. Other hospitals reported senior leadership's role as providing the support and guidance necessary to develop the strategic framework underlying the community benefit activities. Often, senior leaders take an active role in annual organizational strategic planning that incorporates and aligns goals and initiatives, including those based on community health needs and the prior year's outcomes.

Clinical leadership appears to play an active role at most hospitals, with many hospitals reporting that clinical leaders provide community benefit implementation oversight. They provide input into each initiative as it relates to their area of expertise. Population health leaders and staff have varying amounts of responsibility among the hospitals, with some hospitals having dedicated population health personnel, teams, and/or departments.

Internal Audit and Board Review

This section asks whether the hospital conducts an internal audit of the CBR financial spreadsheet and narrative. All hospitals responded to this question. Table 5 shows that 45 out of 49 hospitals conduct an internal audit of the financial spreadsheet, and 40 conduct an internal audit of the narrative report. This section also asks hospitals to describe their internal audit process. Of the 45 hospitals that completed an internal audit, all of them also reported that the CBRs are reviewed by senior leadership. Most hospitals also had their community benefit team review the CBR. Senior leaders involved in the report review included the chief financial officer, the government and regulatory affairs department, the community/population health department, and the clinical integration department.

Table 5. Hospital Internal Audit of the CBR

	Number of Hospitals	
Internal Audit	**Yes**	**No**
Spreadsheet	45 (91.8%)	4 (8.2%)
Narrative	40 (81.6%)	9 (18.4%)

This section also asks whether the hospital board reviews and approves the CBR spreadsheet and narrative. All hospitals responded to this question. Table 6 shows that most hospital boards review and approve the CBR. Of the hospitals that reported that they did not submit their reports for board review, their reasons were largely timing issues. For instance, one hospital reported that their board meets twice a year, so they will not review the report until they meet in the first quarter of 2017. Another hospital reported that the board gives executive staff authority to complete and submit all forms.

Table 6. Hospital Board Review of the CBR

	Number of Hospitals	
Board Review	**Yes**	**No**
Spreadsheet	43 (87.8%)	6 (12.2%)
Narrative	42 (85.7%)	7 (14.3%)

Section IV. Community Benefit External Collaboration

The CBR requires Maryland hospitals to describe their engagement with external partners as follows.

> *"External collaborations are highly structured and effective partnerships with relevant community stakeholders aimed at collectively solving the complex health and social problems that result in health inequities. Maryland hospital organizations should demonstrate that they are engaging partners to move toward specific and rigorous processes aimed at generating improved population health. Collaborations of this nature have specific conditions that together lead to meaningful results, including: a common agenda that addresses shared priorities, a shared defined target population, shared processes and outcomes, measurement, mutually reinforcing evidence based activities, continuous communication and quality improvement, and a backbone organization designated to engage and coordinate partners."*

All hospitals indicated the categories of external partners with whom they collaborated. The results of this question are presented in Table 7. Local health departments and faith-based community organizations were the most common types of external partners, each with 47 out of 49 hospitals reporting such partnerships. The least common external partner category is behavioral health organizations, with 39 out of 49 hospitals reporting such partnerships. The Community Benefit Workgroup requested a list of the behavioral health organizations that are collaborating with hospitals on community benefit activities. See Appendix D for this list.

Table 7. Hospital External Collaboration with Partners

	Number of Hospitals	
Partners	**Yes**	**No**
Local Health Department	47 (95.9%)	2 (4.1%)
Faith-based community organizations	47 (95.9%)	2 (4.1%)
Schools	45 (91.8%)	4 (8.2%)
Other Hospital Organizations	43 (87.8%)	6 (12.2%)
Social service organizations	43 (87.8%)	6 (12.2%)
Local Health Improvement Coalitions	41 (83.7%)	8 (16.3%)
Behavioral Health Organizations	39 (79.6%)	10 (20.4%)

Hospitals were also asked whether their staff participate on their Local Health Improvement Coalition (LHIC). All hospitals responded to this question, and the results are presented in Table 8. Of the 49 hospitals submitting reports, 44 indicated that their staff participate on the LHIC. Of those, 18 hospitals reported that their staff member(s) co-chair the LHIC for their area.

Table 8. Hospital External Collaboration with LHICs

	Number of Hospitals	
Question	**Yes**	**No**
Is there a member of the hospital organization that is co-chairing the LHIC in the jurisdictions where the hospital organization is targeting community benefit dollars?	18 (36.7%)	31 (63.3%)
Is there a member of the hospital organization that attends or is a member of the LHIC in the jurisdictions where the hospital organization is targeting community benefit dollars?	44 (89.8%)	5 (10.2%)

Hospitals were asked to describe the collaborative activities with their partners. Hospitals provided varying levels of detail about these activities. Many hospitals reported hosting and co-hosting community events, community focus groups, and health education programs. Many also reported that partners assisted in the CHNA process.

Section V. Hospital Community Benefit Program and Initiatives

Primary Needs Identified Through the CHNA Process

This section of the CBR collects details about the community benefit initiatives the hospitals undertook during the fiscal year. These initiatives must target the community health needs identified through the CHNA process. Hospitals are asked to highlight the details of select initiatives; they are not asked to report on all initiatives. All but one hospital provided complete responses to these questions. Table 9 shows the number of hospitals that reported targeting initiatives at a number of community health needs. The most common CHNA-identified need targeted by hospitals' initiatives was cardiovascular health, with 29 hospitals. The least common need, targeted by one hospital, was brain injury diagnosis and treatment.

Table 9. Community Health Needs Targeted by Maryland Hospitals' Community Benefit Initiatives, FY 2016

Community Health Needs	Number of Hospitals Reporting CB Initiatives Targeting the Need
Cardiovascular Health (Includes Heart Disease, Hypertension, Stroke)	29
Obesity, Overweight, Nutrition, Exercise	24
Behavioral Health (Includes Mental Health and Substance Use Disorder)	22
Diabetes Prevention & Management	19
Multicultural Outreach & Community Integration/Health Education & Literacy	19
Maternal and Child Health (Includes Infant Mortality)	17
Access to Care - Overall/Comprehensive/Specialty	15
Chronic Illness/Disease - Care Coordination, Management, Palliative Care, etc.	15
Access to Care - Primary & Preventive	14
Cancer Diagnosis and Treatment	14
Respiratory Health (Includes Asthma, Smoking)	12
ED/EMS Usage Reduction	6
Senior Health	5
Healthy Economy (Includes Employment, Job Training, etc.)	4
Violence Prevention - Youth, Street, Domestic	4
Access to Safe, Affordable Housing	3
Provider Shortages	3
Access to Care - Dental	2
Education (Graduation Rate, Access, etc.)	2
HIV/AIDS Screening, Prevention, Treatment	2
Brain Injury Diagnosis and Treatment	1

Cardiovascular Health

Cardiovascular health was the top CHNA-identified need targeted by hospitals. Hospitals took varying approached to meet the goal of improving cardiovascular health in the community. Awareness was a key objective. Many hospitals reported providing community education opportunities in locations such as community centers, schools, and in collaboration with faith-based partners.

In addition to education and prevention, some hospitals targeted the transition between a patient's hospital stay and follow-up with health care providers in the community. For example, one hospital opened a clinic that focused on high risk patients with heart failure or chronic obstructive pulmonary disease who need assistance with the transition between their hospital stay and their follow-up with their health care provider. The clinic serves as a resource to help transition patients until they are able to see their provider for follow up care. The long-term goal of this program is to expand the offerings to patients facing other co-morbidities who are high risk for readmission.

Obesity, Overweight, Nutrition, Exercise

This was the second most common CHNA-identified need targeted by hospitals' initiatives. Many hospitals emphasized obesity and the risk for chronic health problems, such as heart disease, type 2 diabetes, cancer, stroke, asthma, and arthritis. Community benefit activities included public education and outreach on a variety of obesity-related health risks and prevention activities. Activities also included wellness exams, physicals, and exercise programs.

Behavioral Health

Hospitals had varying approaches to addressing behavioral health needs in their communities. Some reported engaging in education and outreach activities. Other hospitals undertook activities to address gaps in mental health professional availability by providing training and continued learning opportunities for such individuals as students, mental health professionals, and individuals such as guidance counselors and corrections officers who may not be mental health professionals, but who may often interact with individuals with mental health needs.

Primary Community Health Needs Not Addressed

The CBR asks hospitals about community health needs identified through the CHNA process that were not addressed. Thirty-nine hospitals reported that one or more primary community health needs were not addressed, ten reported that all were being addressed, and three hospitals did not respond to the question. Of the hospitals that reported that one or more primary community health needs were not addressed, the most frequently reported reason was inadequate resources to address all of the needs. For example, some hospitals reported that they are not currently focusing on top health concerns identified by the CHNA due to the lack of available resources necessary to make the most impactful changes in these areas. The needs were incorporated into the strategic plan, where appropriate. Specific needs not addressed by other

hospitals included oral health, injury and violence prevention, HIV and sexually transmitted diseases, alcohol abuse, and illiteracy.

Community Benefit Operations/Activities Related to State Initiatives

Hospitals were asked how their community benefit operations/activities work toward the state's initiatives for improvement in population health, as identified by the State Health Improvement Process (SHIP) and the Community Health Resources Commission. These include efforts to integrate medical care with community-based resources, a framework and measures (with targets) in distinct focus areas to continue to promote optimal health for all Maryland residents, promoting programs that enhance patient care and population health, and efforts to expand access to health care in underserved communities. Also, in the context of the state's All-Payer Model, hospitals are tasked with improving quality, including decreasing 30-day readmissions. Three hospitals did not respond to this question. Hospital responses varied from dedication to professional education, engagement with community-based organizations to provide resources at no cost, supporting tobacco cessation efforts in the hospital and in the community, flu vaccination programs, and utilizing electronic medical records for better patient tracking and to achieve health outcomes.

Section VI. Physicians

Gaps in Availability

Under Maryland law, hospitals are required to provide a written description of gaps in the availability of specialist providers to serve the uninsured cared for by the hospital.[30] All hospitals responded to this question. Table 10 shows the gaps in availability that were submitted and the number of hospitals reporting each gap. The most frequently reported gap was mental health/psychiatry (reported by 20 hospitals), and the least frequently reported gaps were intensive care, mammography, and wound care (each reported by 1 hospital). Six hospitals reported no gaps.

Table 10. Gaps in Availability

Physician Specialty Gap	Number of Hospitals
No Gaps	6
Mental Health/Psychiatry	20
Internal Medicine	16
Dermatology	13
Dental/Oral/Maxillofacial Surgery	11
Neurosurgery/Neurology	11
Primary Care	11
General Surgery	10

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

Physician Specialty Gap	Number of Hospitals
Otolaryngology	10
Orthopedic Specialties	9
Obstetrics	7
Ophthalmology	6
Substance Abuse/Detoxification	6
Vascular Surgery	6
Cardiac/Thoracic Surgery	2
Anesthesiology	4
ED Coverage	4
Inpatient and Outpatient Care Provider Shortage	4
Geriatrics	3
Gynecology	3
Occupational Therapy/Physical Therapy/ Speech Therapy	3
Pediatrics	3
Podiatry	3
Urology	3
Diagnostic Radiology	2
Medication Assistance	2
Nurse Practitioner	2
Physicians to Refer to after Community Screening Programs	2
Plastic Surgery	2
Intensive Care	1
Mammography	1
Wound Care	1

Physician Subsidies

Hospitals that report physician subsidies as a community benefit category are required to further explain why the services would not otherwise be available to meet patient demand. The physician subsidy categories include: hospital-based physicians with whom the hospital has an exclusive contract; non-resident house staff and hospitalists; coverage of emergency department call; physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; and physician recruitment to meet community need. Forty-one hospitals listed at least one category of subsidy.

Section VII. Appendices

The CBR also requires the hospitals to submit two categories of appendices: financial assistance policies and their mission, vision, and values statements. All hospitals submitted copies of their mission, vision, and values statements.

Financial Assistance Policies

The CBR requires hospitals to submit four documents related to financial assistance policies:

- A description of the policy (submitted by all hospitals)
- A description of how the policy changed since the enactment of the coverage expansions under the Affordable Care Act (submitted by all but two hospitals)
- A copy of the financial assistance policy (submitted by all hospitals)
- A copy of the patient information sheet provided to patients in accordance with Health-General §19-214.1(e) (submitted all hospitals)

Maryland regulations set out the requirements for hospitals to provide free or reduced cost care as part of their financial assistance policies.[31] Patients with family income at or below 200 percent of the FPL qualify for free medically necessary care.[32] In FY 2016, 41 hospitals reported that they provide free care at the threshold required in regulation, 7 hospitals reported a higher/more generous threshold, 1 hospital reported a threshold lower than the regulatory requirement (150 percent of the FPL), 1 hospital provided financial assistance eligibility criteria that did not explicitly state that it provides free care below the threshold, and 2 hospitals did not include their thresholds in the policies.

Regulations also require hospitals to provide reduced-cost, medically necessary care to patients with family income between 200 and 300 percent of the FPL.[33] Twenty-one hospitals report providing reduced cost care at this threshold, 22 hospitals reported a more generous threshold (as high as 600 percent of the FPL), 2 hospitals provided information about their policy but not the specific FPL threshold, and 6 hospitals did not provide this information.

Hospitals must also provide for reduced-cost, medically-necessary care to patients with family income below 500 percent of the FPL who have a financial hardship; some hospitals call this the financial hardship policy.[34] In order to have a financial hardship, the medical debt incurred by a family over a 12-month period must exceed 25 percent of family income.[35] Thirty-five hospitals reported having policies at this threshold. Two hospitals reported a more generous policy, allowing for reduced-cost care at 500 percent of the FPL but when debt exceeds 20 percent of family income. One hospital did not state the FPL threshold but indicated that the policy applies

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[31] COMAR 10.37.10.26.
[32] COMAR 10.37.10.26(A-2)(2)(a)(i).
[33] COMAR 10.37.10.26(A-2)(2)(a)(ii).
[34] COMAR 10.37.10.26(A-2)(3).
[35] COMAR 10.37.10.26(A-2)(1)(b)(i).

to debt exceeding only ten percent of family income. Two hospitals indicated that the policy applies to debt exceeding fifty percent of gross income without reference to FPL. Finally, 12 hospitals did not provide this information.

Conclusion

The Community Benefit Narrative Report provides the HSCRC with richer detail on hospital community benefit activities beyond what is included in the financial report. For FY 2016, all 52 hospitals submitted reports. Of those, 40 submitted complete reports with responses to every question, and 12 hospitals did not respond to one or more questions. Some of the missing elements could be obtained from other publicly available data sources. Encouraging findings of the review include senior-level commitment to community benefit activities and community engagement. For example, most hospitals reported that their senior leadership is involved in the implementation and delivery of community benefit activities, and most conduct internal audits and Board reviews and approvals of the CBRs. Roughly 90 percent of the hospitals have staff members participating in LHICs.

The review identified several policy areas for further analysis and/or improvement. In terms of service areas, the review identified 186 ZCTAs in Maryland that are not covered by any hospital CBSA. Further analysis could include: reviewing population health metrics of these gap areas, identifying the hospitals closest to these areas, and reviewing these hospitals' methodologies for defining their CBSAs. Further analysis could also compare the CHNA results and community benefit initiatives among hospitals that share CBSAs in more densely covered areas to help better target resources.

Behavioral health is another potential area for further policy review. Behavioral health was one of the top CHNA-identified needs, and it was identified as the top physician gap by hospitals. At the same time, behavioral health organizations were the least frequently reported community benefit external collaborator.

Finally, the review found that one hospital's reported financial assistance policy does not meet the minimum threshold required in regulation. The HSCRC may consider following up with this hospital.

This review also identified a number areas for improving the CBR reporting tool, including the reporting requirements, the format, and the content of the report. Revisions to the requirements could promote fairness across hospitals and improve report accuracy. Suggestions include:

- Requiring reports for each individual hospital so that report measures are consistent.
- Requiring hospitals to respond to all questions, or providing a justification for a non-response.

Revisions to the format could make the report easier to analyze and reduce reporting burden on the hospitals. Suggestions include:

- Reducing the number of free text questions and replacing with check boxes, response options, and numbers (where applicable).
- Developing an electronic reporting tool, such as through Survey Monkey.
- Pre-populating the report with data available from other sources, including the bed designation, number of admissions, percent Medicare/Medicaid/uninsured, PSAs, and community health measures. This would reduce burden on the hospitals and ensure consistent measurement across hospitals.
- Revising the formatting of the "Community Benefit Initiatives" table so that information for each individual community benefit initiative can be analyzed.

Finally, revisions to the report content could reduce redundancy and collect more targeted information as the state's All-Payer Model progresses. Suggestions include:

- Reviewing the measures and reporting requirements for other HSCRC reports, such as the Global Budget Revenue (GBR) report, and editing questions accordingly.
- Reviewing the community benefit questions on Schedule H and editing accordingly; staff could also explore with stakeholders the possibility of hospitals submitting their Schedule H as an attachment to this report.
- Collecting lists of the community health needs identified through the hospitals' most recent CHNA.
- Creating a specific section on financial assistance policies (these are currently reported as an appendix).
- Providing clarification in the instructions about the reporting of out-of-state community benefit activities.
- Aligning the PSA definition with the GBR PSAs.
- Removing the requirement for hospitals to attach their mission, vision, and values statements, as this information is not easily analyzable and is typically available online.
- Adding questions about community benefit decision-making authority within the hospital.
- Adding questions about community benefit and population health staffing within the hospital.

HSCRC staff have also requested feedback from and will continue to work with the Community Benefit Workgroup on these revisions.

FINANCIAL REPORTS

The financial reports collect information about staff hours, the number of encounters, and direct and indirect costs for community benefits, categorized by type of community benefit activity. The reporting period for these financial data is July 1, 2015, through June 30, 2016. Hospitals submitted their individual CBRs to the HSCRC by December 2016. Audited financial statements were used to calculate the cost of each of the community benefit categories contained in the data reports. Fifty-two hospitals submitted individual data reports.

FY 2016 Financial Reporting Highlights

Table 1 presents a statewide summary of community benefit expenditures for FY 2016. Maryland hospitals provided just over $1.5 billion in total community benefit activities in FY 2016—a total that is slightly higher than FY 2015 ($1.48 billion). The FY 2016 total comprises net community benefit expenses of $492.7 million in mission-driven health care services (subsidized health services), $469.3 million in health professions education, $320.9 million in charity care, $107.2 million in community health services, $56.5 million in unreimbursed Medicaid costs, $6.6 million for Medicaid expansion expenses, $24.7 million in community-building activities, $20.8 million in financial contributions, $13.4 million in community benefit operations, $9.6 million in research activities, and $1.7 million in foundation-funded community benefits. These totals include hospital-reported indirect costs, which vary by hospital and by category from a fixed dollar amount to a calculated percentage of the hospital's reported direct costs.

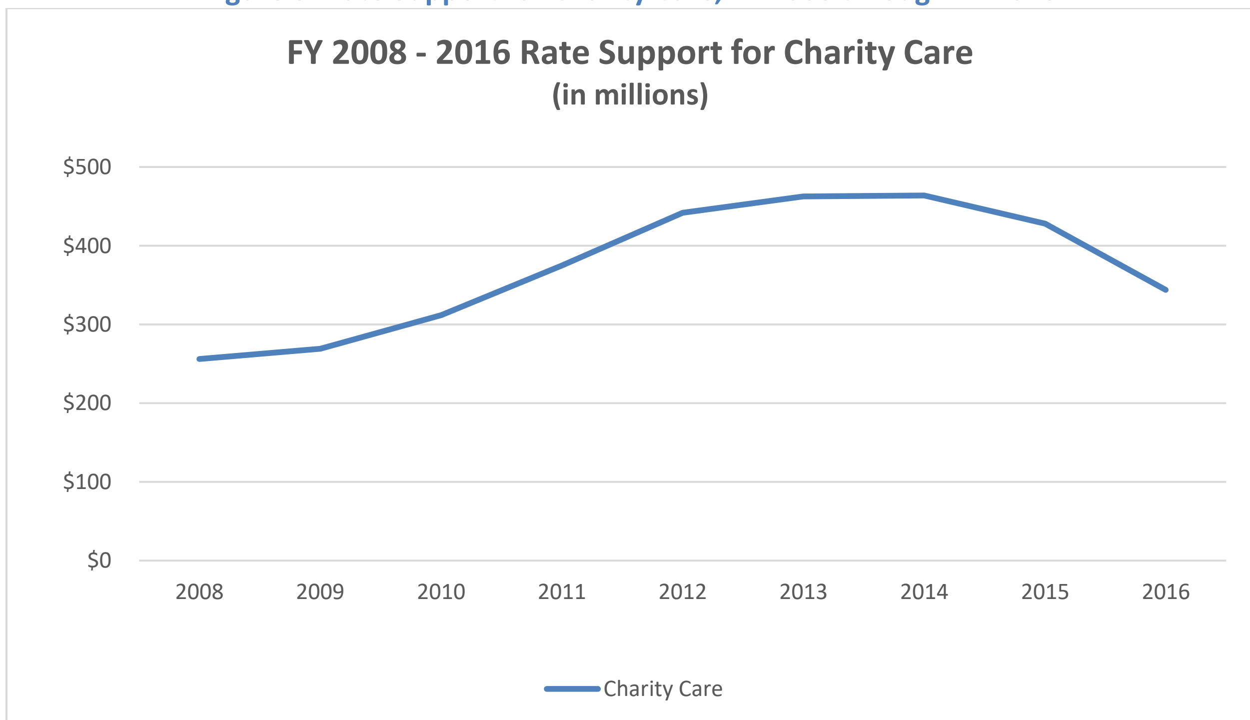
Table 11. Total Community Benefits, FY 2016

Community Benefit Category	Number of Staff Hours	Number of Encounters	Net Community Benefit Expense	% of Total Community Benefit Expenditures	Net Community Benefit Expense Less: Rate Support	% of Total Community Benefit Expenditures w/o Rate Support
Unreimbursed Medicaid Cost	N/A	N/A	$56,475,883	3.71%	$56,475,883	6.82%
Community Health Services	1,242,055	4,036,356	$107,226,253	7.04%	$107,226,253	12.96%
Health Professions Education	5,059,756	180,171	$469,283,494	30.80%	$117,157,540	14.16%
Mission Driven Health Services	2,283,557	937,072	$492,748,329	32.34%	$492,748,329	59.53%
Research	111,091	6,398	$9,649,972	0.63%	$9,649,972	1.17%
Financial Contributions	32,816	191,518	$20,827,391	1.37%	$20,827,391	2.52%
Community Building	253,490	453,394	$24,739,540	1.62%	$24,739,540	2.99%
Community Benefit Operations	113,808	2,531	$13,417,597	0.88%	$13,417,597	1.62%
Foundation	77,881	49,689	$1,742,933	0.11%	$1,742,933	0.21%
Charity Care	N/A	N/A	$320,932,030	21.06%	-$22,947,729	-2.77%
ACA Medicaid Expansion Expense	N/A	N/A	$6,629,446	0.44%	$6,629,446	0.80%
Total	**9,174,456**	**5,857,129**	**$1,523,672,867**	**100%**	**$827,667,153**	**100%**

In Maryland, the costs of uncompensated care (including charity care and bad debt) and graduate medical education are built into the rates for which hospitals are reimbursed by all payers, including Medicare and Medicaid. Additionally, the HSCRC rates include amounts for nurse support programs provided at Maryland hospitals. These costs are, in essence, "passed-through" to the purchasers and payers of hospital care. To comply with IRS Form 990 and avoid accounting confusion among programs that are not funded by hospital rate setting, the HSCRC requests that hospitals exclude from their reports all revenue that is included in rates as offsetting revenue on the CBR worksheet. Appendix E details the amounts that were included in rates and funded by all payers for charity care, direct graduate medical education, and nurse support programs in FY 2016.

As noted above, the HSCRC includes a provision in hospital rates for uncompensated care—which includes charity care—because it is considered to be a community benefit. It also includes bad debt, which is not considered to be a community benefit. Figure 3 shows the rate support for charity care from FY 2008 through FY 2016. The rate support for charity care continuously increased from FY 2008 through FY 2014 and then began to decrease in FY 2014 due to implementation of the ACA. See Appendix E for more details.

Figure 3. Rate Support for Charity Care, FY 2008 through FY 2016



Another social cost funded through Maryland's rate-setting system is the cost of graduate medical education, generally for interns and residents who are trained in Maryland hospitals. Included in graduate medical education costs are the direct costs (i.e., direct medical education,

or DME), which include the residents' and interns' wages and benefits, faculty supervisory expenses, and allocated overhead. The HSCRC's annual cost report quantifies the DME costs of physician training programs at Maryland hospitals. In FY 2016, DME costs totaled $336.4 million.

The HSCRC's Nurse Support Program I (NSPI) is aimed at addressing the short- and long-term nursing shortage affecting Maryland hospitals. In FY 2016, $15.7 million was provided in hospital rate adjustments for the NSPI. See Appendix E for detailed information about funding provided to specific hospitals.

When the reported community benefit costs for Maryland hospitals were offset by rate support, the net community benefits provided in FY 2016 totaled $827.7 million, or 5.07 percent of total hospital operating expenses. This is an increase from the $731.2 million in net benefits provided in FY 2015, which totaled 4.98 percent of hospital operating expenses. See Appendix F: FY 2016 Community Benefit Analysis for additional detail.

Table 12 presents staff hours, the number of encounters, and expenditures for health professional education by activity. The education of physicians and medical students makes up the majority of expenses in the category of health professions education, totaling $414 million. The second highest category is the education of nurses and nursing students, totaling $28.2 million. The education of other health professionals totaled $19.0 million.

Table 12. Health Professions Education Activities and Costs, FY 2016

Health Professions Education	Number of Staff Hours	Number of Encounters	Net Community Benefit with Indirect Cost
Physicians and Medical Students	4,020,097	39,858	$414,332,259
Nurses and Nursing Students	569,151	50,236	$28,203,306
Other Health Professionals	340,101	51,710	$18,997,589
Other	123,644	37,043	$4,441,604
Scholarships and Funding for Professional Education	6,763	1,324	$3,308,736
Total	**5,059,756**	**180,171**	**$469,283,494**

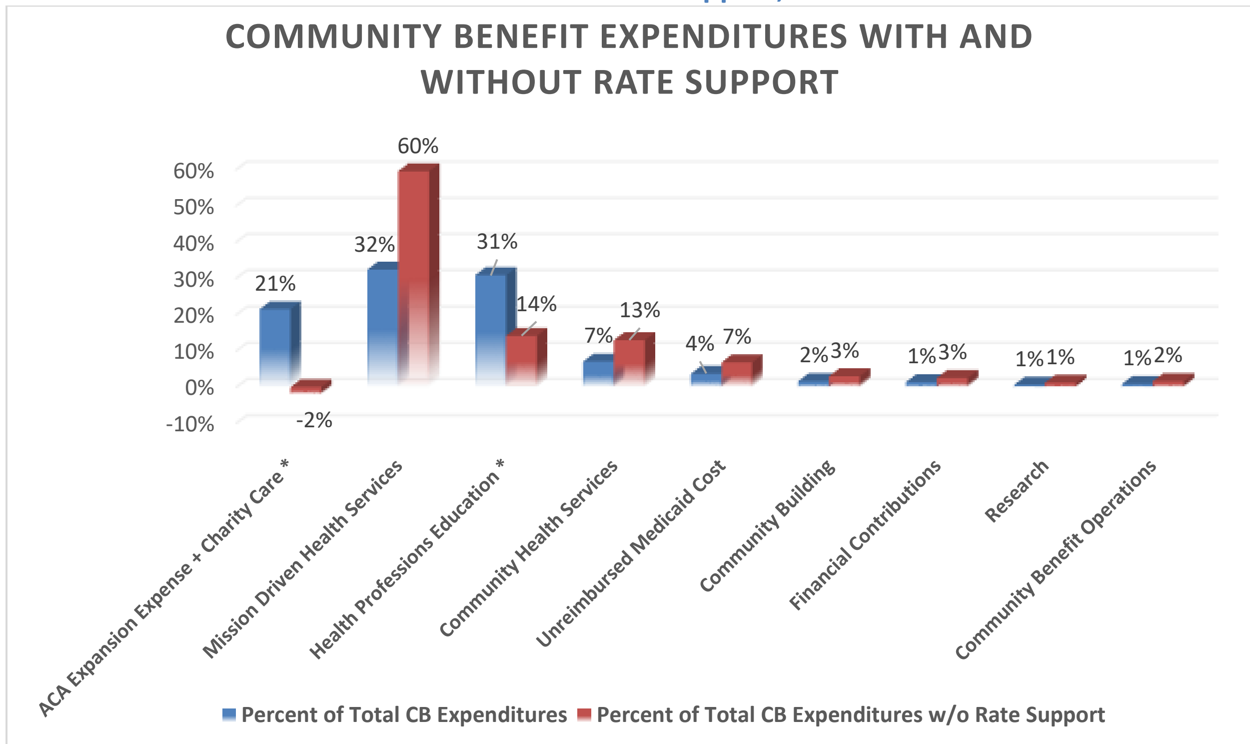
Table 13 presents staff hours, the number of encounters, and expenditures for community health services by activity. Health care support services comprise the largest portion of expenses in the category of community health services, totaling $42.2 million. Community health education is the second highest category, totaling $28.4 million, and community-based clinical services is the third highest, totaling $13.0 million. For additional detail, see Appendix G FY 2016 Hospital Community Benefit Aggregate Data.

Table 13. Community Health Services Activities and Costs, FY 2016

Community Health Services	Number of Staff Hours	Number of Encounters	Net Community Benefit with Indirect Cost
Health Care Support Services	269,924	204,933	$42,209,362
Community Health Education	382,161	3,038,413	$28,362,877
Community-Based Clinical Services	377,919	324,994	$13,000,587
Other	57,417	140,515	$9,676,518
Free Clinics	37,374	40,476	$6,745,598
Screenings	36,882	81,415	$2,745,610
Support Groups	16,359	36,353	$1,831,863
Self-Help	29,563	145,047	$1,555,894
Mobile Units	30,965	10,261	$759,321
One-Time/Occasionally Held Clinics	3,491	13,949	$338,621
Total	**1,242,055**	**4,036,356**	**$107,226,253**

Rate offsetting significantly affects the distribution of expenses by category. Figure 4 shows expenditures in each community benefit category as a percentage of total expenditures. Charity care, health professions education, and mission-driven health services represent the majority of the expenses, at 21 percent, 31 percent, and 32 percent, respectively. Figure 4 also shows the percentage of expenditures by category without rate support, which changes the configuration significantly: Mission-driven health services becomes the category with the highest percentage of expenditures, at 60 percent. Health professions education follows, with 14 percent of expenditures, and community health services accounts for 13 percent of expenditures.

Figure 4. Percentage of Community Benefit Expenditures by Category with and without Rate Support, FY 2016



*Rate Supported Activities

Utilizing the data reported, Appendix F compares hospitals on the total amount of community benefits reported, the amount of community benefits recovered through HSCRC-approved rate supports (i.e., charity care, direct medical education, and nurse support), and the number of staff and staff hours dedicated to community benefit operations. On average, in FY 2016, 2,189 staff hours were dedicated to community benefit operations, an increase of 21 percent from 1,803 staff hours in FY 2016. Seven hospitals reported zero staff hours dedicated to community benefit operations, the same number as in FY 2015. The HSCRC continues to encourage hospitals to incorporate community benefit operations into their overall strategic planning.

The total amount of community benefit expenditures as a percentage of total operating expenses ranged from 1.45 percent to 24.80 percent, with an average of 9.5 percent, the same as in FY 2015. Nineteen hospitals reported providing benefits in excess of 10 percent of their operating expenses, compared with 15 hospitals in FY 2015.

FY 2004 – FY 2016 13-Year Summary

FY 2016 marks the 13th year since the inception of the CBR. In FY 2004, community benefit expenses represented $586.5 million, or 6.9 percent of operating expenses. In FY 2016, these expenses represented over $1.5 billion, or 9.3 percent of operating expenses. As Maryland hospitals have increasingly focused on implementation of cost- and quality-improvement

strategies, an increasing percentage of operating expenses has been directed toward community benefit initiatives.

The reporting requirement for revenue offsets and rate support has changed since the inception of the CBR in FY 2004. For consistency purposes, the following figures illustrate community benefit expenses from FY 2008 through FY 2016. Figures 5 and 6 show the trend of community benefit expenses with and without rate support. On average, approximately 50 percent of expenses were reimbursed through the rate-setting system.

Figure 5. FY 2008 – FY 2016 Community Benefit Expenses with and without Rate Support

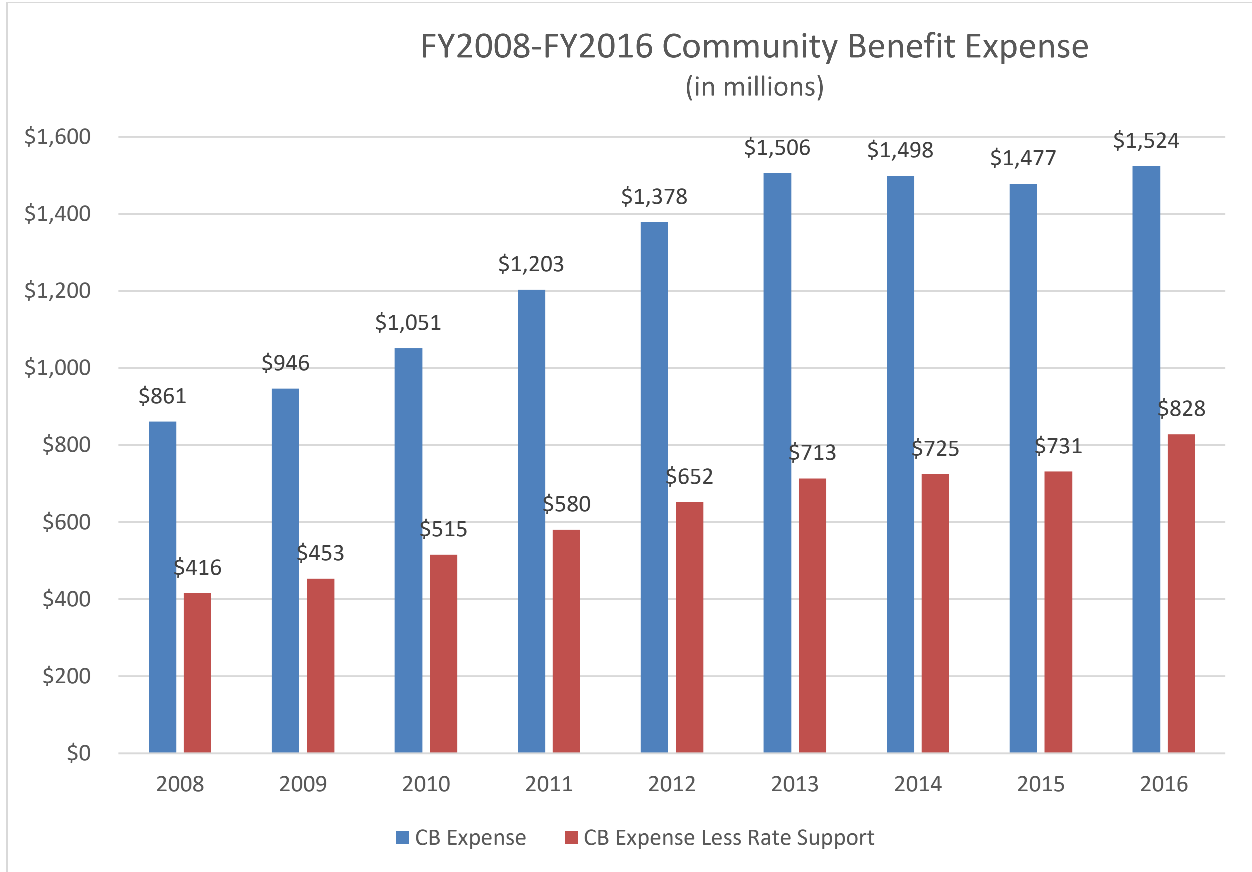
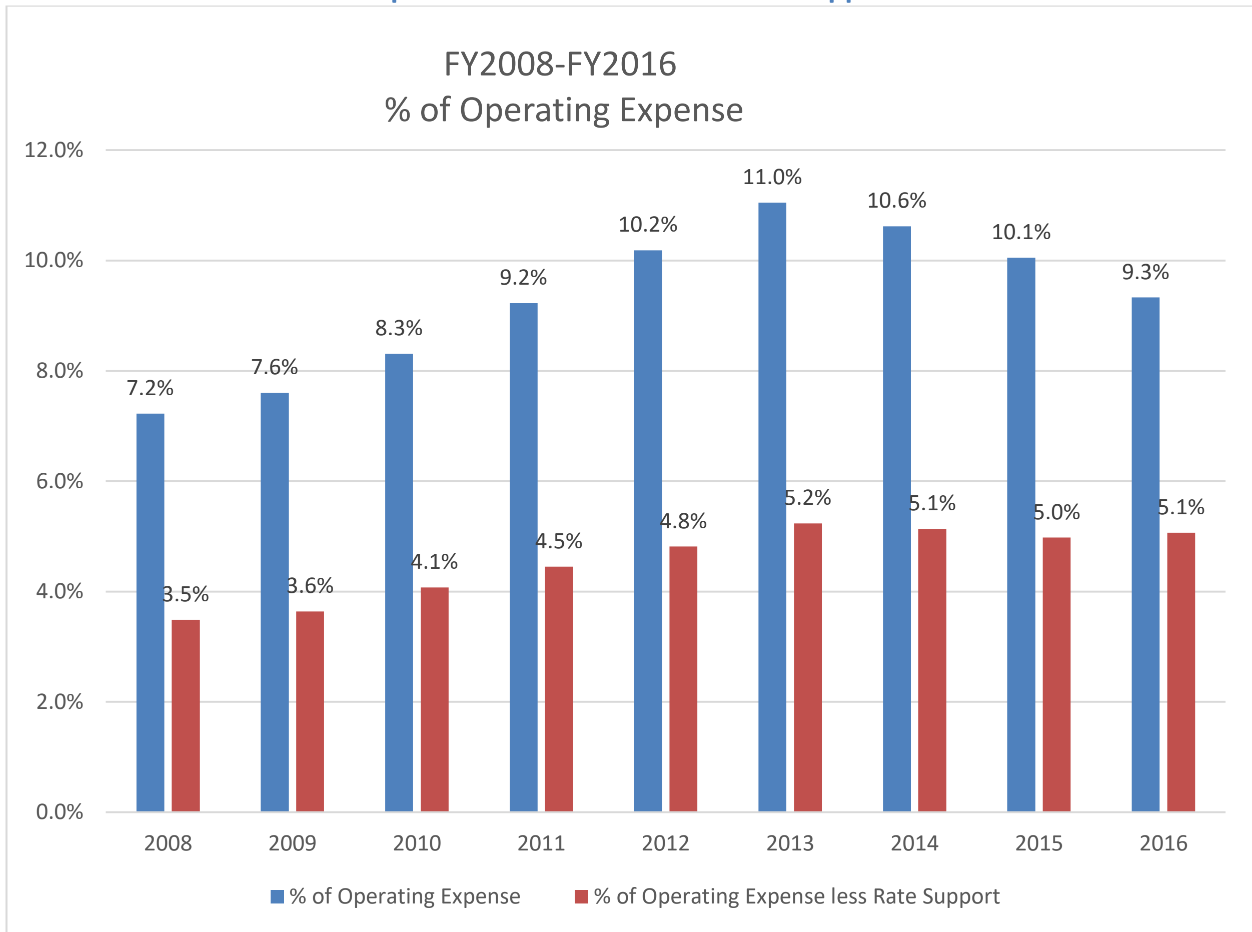


Figure 6. FY 2008 – FY 2016 Community Benefit Expenses as a Percentage of Operating Expenses with and without Rate Support



APPENDIX A. ZIP CODE LISTS

Appendix A Table 1. List of ZIP Codes not Covered by Any CBSA

ZIP Codes	ZCTA
20606	20606
20608	20608
20609	20609
20610	20678
20615	20615
20618	20618
20619	20619
20620	20620
20621	20621
20623	20623
20624	20624
20626	20626
20627	20650
20628	20628
20629	20657
20630	20630
20634	20634
20635	20659
20636	20636
20639	20639
20650	20650
20656	20656
20660	20659
20667	20667
20670	20670
20674	20674
20676	20676
20680	20680
20684	20684
20685	20685
20686	20653
20687	20687
20688	20688
20689	20689
20690	20690
20692	20692
20697	20877
20703	20785

ZIP Codes	ZCTA
20704	20705
20709	20708
20710	20710
20712	20712
20717	20716
20718	20715
20719	20715
20722	20722
20725	20707
20726	20707
20731	20743
20732	20732
20738	20737
20741	20740
20746	20746
20749	20744
20750	20745
20752	20746
20753	20747
20757	20748
20762	20762
20768	20770
20769	20769
20771	20770
20773	20772
20775	20772
20787	20783
20788	20782
20790	20748
20791	20748
20792	20774
20797	20743
20799	20743
20810	20814
20811	20814
20812	20812
20813	20815
20816	20816

ZIP Codes	ZCTA
20818	20818
20824	20814
20825	20815
20827	20817
20830	20832
20833	20833
20837	20837
20838	20838
20839	20839
20841	20841
20842	20842
20847	20852
20848	20851
20849	20850
20857	20852
20859	20854
20860	20860
20861	20861
20862	20862
20871	20871
20872	20872
20875	20874
20880	20877
20882	20882
20883	20878
20884	20877
20885	20877
20889	20814
20891	20895
20892	20814
20894	20814
20896	20895
20897	20877
20898	20877
20899	20878
20907	20910
20908	20906
20911	20910

ZIP Codes	ZCTA
20913	20912
20914	20904
20915	20902
20916	20903
20918	20901
20993	20855
20997	20878
21018	21001
21020	21155
21022	21204
21023	21152
21027	21220
21031	21031
21051	21051
21052	21219
21053	21053
21065	21031
21071	21071
21088	21102
21092	21057
21105	21053
21128	21128
21130	21001
21131	21131
21139	21204
21152	21152
21153	21153
21156	21156
21162	21162
21203	21202
21210	21210
21233	21202
21235	21207
21241	21207
21250	21204
21251	21204
21252	21204
21263	21202

ZIP Codes	ZCTA
21264	21201
21270	21215
21273	21218
21275	21202
21278	21218
21279	21202
21280	21202
21281	21286
21282	21204
21284	21204
21285	21286
21287	21205
21288	21202
21289	21207
21290	21207
21297	21202
21298	21202
21522	21522
21523	21523
21536	21536
21607	21607
21609	21655
21610	21610
21612	21612
21619	21619
21622	21622

ZIP Codes	ZCTA
21623	21623
21624	21663
21625	21625
21626	21626
21627	21627
21628	21651
21634	21634
21635	21635
21636	21636
21638	21638
21639	21639
21640	21640
21641	21629
21644	21644
21645	21645
21647	21647
21648	21648
21649	21649
21650	21650
21651	21651
21652	21612
21653	21663
21654	21654
21656	21623
21657	21657
21658	21658

ZIP Codes	ZCTA
21659	21659
21660	21660
21662	21662
21664	21631
21665	21665
21666	21666
21667	21667
21668	21668
21669	21669
21670	21649
21671	21671
21672	21672
21673	21673
21675	21675
21676	21676
21677	21677
21679	21679
21690	21660
21705	21702
21709	21702
21714	21703
21715	21758
21717	21703
21720	21783
21721	21742
21734	21742

ZIP Codes	ZCTA
21741	21740
21746	21740
21747	21740
21749	21742
21759	21757
21762	21701
21775	21757
21781	21733
21792	21776
21795	21795
21802	21801
21803	21801
21810	21801
21826	21826
21835	21835
21836	21871
21852	21850
21857	21838
21866	21866
21867	21871
21869	21869
21890	21871
21922	21921

Appendix A Table 2. List of CBSA ZIP Codes Covered by 8 or More Hospitals

ZIP Codes	ZCTA
21215	21215
21216	21216
21217	21217

APPENDIX B. COMMUNITY HEALTH MEASURES REPORTED BY HOSPITALS

In addition to the measures reported in Table 3 of the main body of this report, hospitals reported a number of other community health measures.

Measure	Source
% Below FPL/Uninsured By Race/Ethnicity	US Census, ACS
Infant Mortality Rate by Race/Ethnicity	DHMH SHIP
Fruit/Vegetable Consumption	CHNA; Healthy Montgomery
Food Insecurity Rate	Feeding America, Map the Meal Gap
Number of Grocery Stores	CHNA; US Census Bureau, County Business Patterns
Number of Fast Food Restaurants/Fast Food Density	CHNA; US Census, County Business Patterns
Means of Transportation to Work	US Census, ACS
Rate of Pedestrian Injuries	DHMH SHIP
Traffic Fatalities	National Highway Traffic Safety Administration, Safety Facts 2014
High School Graduation Rate by Race/Ethnicity	2016 Maryland Report Card
Bachelor's or Higher by Race/Ethnicity	US Census, ACS
12th Grade Students Proficient in English by Race/Ethnicity	2016 Maryland Report Card
12th Grade Students Proficient in Algebra by Race/Ethnicity	2016 Maryland Report Card
Readiness for Kindergarten by Race/Ethnicity	DHMH SHIP
Severity of Housing Problems by Race/Ethnicity	US Census, American Housing Serving, 2015
Homelessness	Metropolitan Washington Council on Governments Point-In-Time Survey, 2016; Community Health Needs Assessment, Anne Arundel County, 2016
Air Pollution	Healthy Communities Institute, 2016
Population 25+ w/o HS Diploma	US Census
Wait List for Public Housing/Section 8	Community Health Needs Assessment, Anne Arundel County, 2016
Death Rate: Coronary Heart Disease	DHMH SHIP
Death Rate: Stroke	DHMH SHIP
Death Rate: Diabetes	DHMH SHIP
ED Visits: General	DHMH SHIP
ED Visits: Diabetes	DHMH SHIP

ED Visits: Asthma	DHMH SHIP
ED Visits: Hypertension	DHMH SHIP
Food desert	Community Health Needs Assessment, Anne Arundel County, 2016
% on SNAP or Food Stamps	Community Health Needs Assessment, Anne Arundel County, 2016 / US Census
Food Insecurity Index	County Health Rankings
Annual Ozone Air Quality (2010)	American Lung Association
Severe Housing Problem	County Health Rankings
Population per Physician	Not provided
Liquor Outlet Density	US Census, County Business Patterns
Children's Blood Lead Levels	Not provided
% of Residents that Travel outside of County for Medical Care	Not provided
# of FQHCs	Not provided
% Physician Shortage Specialties	Not provided
Death rate: Breast cancer	Not provided
County health rankings table (quality of life, health behaviors, clinical care, social & economic factors, physical enviro)	County Health Rankings
Air Pollution: Particulate Matter	County Health Rankings
Water Pollution: Drinking water violations	Not provided
SNAP Retailers	US Dept. of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator
WIC Retailors	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2011.
% Substandard Housing Units	US Census, ACS
% Overcrowded Housing	US Census, ACS
Rate of Recreation and Fitness Facilities	US Census, County Business Patterns
% of Days Exceeding Emission Standards for Ozone Levels	CDC, EPHT
% of Days Exceeding the Particulate Matter 2.5* Standards	CDC, EPHT
All SHIP Indicators	DHMH SHIP
Free school lunch eligibility	County Health Rankings
# of Safety Net Clinics	PG County Health Improvement Plan
Limited Access to Healthy Foods	County Health Rankings
% Smokers	DHMH SHIP

% of renters who are paying 30% or more on their household income in rent:	Not provided
Teen Birth Rate	Not provided
% of Live Births with Inadequate Birth Spacing	Not provided
% of Women Receiving Prenatal Care in 1st Trimester	Not provided
Mental Health Providers to population	County Health Rankings
Violent Crime	County Health Rankings
Low Birth Weight	DHMH SHIP
Rate of Hospital Encounters for Newborns with Maternal Drug/Alcohol Exposure	HSCRC Hospital Data, 2000-2015, Maryland resident births only
Adolescents Who Use Tobacco Products	SHIP 2013, Maryland Youth Risk Behavior Survey (YRBS)
Percentage of Adults who currently smoke	Maryland DHMH Behavioral Risk Factor Surveillance System (BRFSS)
Physical Activity	Maryland DHMH Behavioral Risk Factor Surveillance System (BRFSS)

APPENDIX C. CHNA SCHEDULES

Hospital	Date Most Recent CHNA was Completed as Reported on Hospital Website or FY 16 CBR
GBMC	Mar 2013
Western Maryland	Dec 2013
McCready	Oct 2014
Calvert Memorial	Dec 2014
Charles Regional	Mar 2015
Lifebridge-Carroll Hospital	Jun 2015
UM-Midtown	Jun 2015
UMMC	Jun 2015
Mt. Washington Pediatrics	Jun 2015
UM-Rehab and Ortho	Jun 2015
MedStar Franklin Square	Jun 2015
MedStar Good Samaritan	Jun 2015
Medstar Harbor	Jun 2015
MedStar Montgomery	Jun 2015
MedStar Southern Maryland	Jun 2015
MedStar St. Mary's	Jun 2015
MedStar Union Memorial	Jun 2015
UM Harford Memorial	Jun 2015
UM Upper Chesapeake	Jun 2015
Meritus	Nov 2015
Anne Arundel	Feb 2016
UM-BWMC	Feb 2016
UM-St. Joseph	Apr 2016
Lifebridge-Northwest	Apr 2016
Lifebridge-Sinai	Apr 2016
Atlantic General	May 2016
Garrett Regional	May 2016
Sheppard Pratt	May 2016
Shore Health Chestertown	May 2016
Shore Health Dorchester	May 2016
Shore Health Easton	May 2016
Mercy	Jun 2016
Dimensions Laurel Regional Hospital	Jun 2016
Dimensions Prince Georges Hospital Center	Jun 2016
Doctors Community	Jun 2016

Hospital	Date Most Recent CHNA was Completed as Reported on Hospital Website or FY 16 CBR
Johns Hopkins Bayview	Jun 2016
Fort Washington	Jun 2016
Suburban	Jun 2016
Johns Hopkins Hospital	Jun 2016
St. Agnes	Jun 2016
Peninsula Regional	Jun 2016
Howard County General	Jun 2016
Lifebridge-Levindale	Jun 2016
Union Hospital of Cecil County	Jun 2016
Frederick Memorial	Sep 2016
Holy Cross Germantown	Oct 2016
Holy Cross Hospital	Oct 2016
Shady Grove	Nov 2016
Washington Adventist	Nov 2016
Adventist Behavioral Health	Nov 2016
Adventist Rehab	Nov 2016
Bon Secours	Dec 2016

*Data Source: As reported by hospitals on their FY 2016 Community Benefit Reports and edited according to hospital websites

APPENDIX D. BEHAVIORAL HEALTH PARTNER ORGANIZATIONS

The Community Benefit Workgroup requested information on the behavioral health organizations that are partnering with hospitals on community benefit activities. The following tables lists the behavioral health organizations reported in the CBRs.

<table>
<tr><th colspan="2">Government Organizations</th></tr>
<tr><td rowspan="2">Alcohol and Drug Abuse Administration</td><td>Kent County Department of Health Addiction Services</td></tr>
<tr><td>Maryland Department of Education</td></tr>
<tr><td>Anne Arundel County Courts</td><td>Maryland Department of Health and Mental Hygiene</td></tr>
<tr><td>Anne Arundel County Department of Health</td><td>Mayor's Office of Human Services</td></tr>
<tr><td>Anne Arundel County Department of Juvenile Justice</td><td>Montgomery County Department of Health and Human Services</td></tr>
<tr><td>Anne Arundel County Executive's Office</td><td>Naval Air Station PAX River</td></tr>
<tr><td>Anne Arundel County Public Schools Staff</td><td>Office of Drug Control Policy</td></tr>
<tr><td>Anne Arundel Mental Health Agency</td><td>Office on Mental Health - Core Services Agency</td></tr>
<tr><td>Baltimore City Health Department</td><td>Partnership for Children Youth and Families</td></tr>
<tr><td>Baltimore City Office of Homeless Services</td><td>Queen Anne's County Department of Health - Addictions Treatment and Prevention Services</td></tr>
<tr><td>Baltimore City Police Department</td><td>St. Mary's County Alcohol Beverage Board</td></tr>
<tr><td>Behavioral Health Administration</td><td>St. Mary's County Core Services Agency</td></tr>
<tr><td>Carroll County Health Department</td><td>St. Mary's County Department of Aging and Human Services</td></tr>
<tr><td>Cecil County Health Department</td><td>St. Mary's County Department of Social Services</td></tr>
<tr><td>Charles County Commissioners</td><td>St. Mary's County Drug Court</td></tr>
<tr><td>Charles County Core Services Agency</td><td>St. Mary's County Health Department</td></tr>
<tr><td>Charles County Department of Health</td><td>St. Mary's County Public Schools</td></tr>
<tr><td>Charles County Public Schools</td><td>St. Mary's County Sherriff's Office</td></tr>
<tr><td>Charles County Sherriff's Office</td><td>State's Attorney's Opioid Task Force</td></tr>
<tr><td>Circuit Court of Talbot County, Problem Solving Court</td><td>Substance Abuse and Mental Health Services Administration</td></tr>
<tr><td rowspan="2">Department of Community Services</td><td>Talbot County Health Department Addictions Program (TCAP) and Prevention</td></tr>
<tr><td>The Washington County Mental Health Authority (CSA)</td></tr>
</table>

Dorchester County Addictions Program	Washington County Health Department/LHIC
Frederick County Health Department	Wicomico County Health Department
Harford County Health Department	Worcester County Drug and Alcohol Board
Howard County Health Department	Worcester County Health Department
Howard County Mental Health Authority	Worcester County Public Schools
Faith-Based Organizations	
Helping Up Mission	Southern Baptist Church
Israel Baptist Church	Talbot Association of Clergy and Laity
Mount Lebanon Baptist Church	Zion Baptist Church
Providers, Hospitals, and Treatment Organizations	
Access Carroll	Lower Shore Health Clinic Go-Getters
Adult Substance Abuse Services	Maryland Quit Line
Adventist Behavioral Health	Medicine for the Greater Good
Alcoholics Anonymous	Mid-Shore Mental Health System
Anne Arundel Mobile Crisis Unit	Mosaic
Atlantic Health Clinic	Mountain Laurel Health Center
Baltimore Crisis Response, Inc.	Pathways Inc.
Behavioral Health Action Team	Potomac Case Management
Caroline Counseling Center	Prince George's Hospital Center, Family Medicine Residency Program
Caroline County Prevention Services	QCI Behavioral Health
Carroll County Youth Services Bureau	Riverside Health System
Catoctin Counseling	Sheppard Pratt
Chesapeake Treatment Services	
Chesapeake Voyagers, Inc.	Shoemaker Center
Cheverly Family Health & Wellness, Behavioral Services	St. Paul Place Specialists
Choptank Community Health System	Surfer's Healing Camps
Crisis Response Team Advisory Board	The Mental Health Center
Dayspring	Three Lower Counties Clinic
Dri-Dock Recovery and Wellness Center	University of Maryland Baltimore Washington Medical Center
Drug Overdose Fatality Review Team	University of Maryland Medical Center
Family Medicine Practice Family Health and Wellness Center, Cheverly	Vesta, Inc.
Freedom Landing	Walden Sierra
Grassroots Crisis Intervention Center	Warwick Manor Behavioral Health
Healthcare for the Homeless	Washington Adventist Hospital
Hudson Health Services	Way Station, Inc.

Johns Hopkins Medicine	West Cecil Health Center
Lower Shore Clinic	Worcester Youth and Family Services
Lower Shore Critical Incident Crisis Management	
Other Organizations	
The Horizon Foundation	WOW Committee
United Way of Central Maryland	
Alzheimer's Association, Prince George's County Chapter	Mental Health Association of Montgomery County
American Academy of Pediatrics	Minority Outreach Coalition
American Foundation for Suicide Prevention	National Alliance on Mental Illness
Autism Speaks	Ocean City Drug and Alcohol Abuse and Prevention Committee
	On Our Own
BACH/Baltimore Alliance for Careers in Healthcare	Parents Affected by Addiction
Beans and Bread	Patients Like Me
Behavioral Health Systems Baltimore	Play it Safe Committee
Charles County Substance Abuse Advisory Committee	Port Towns Community Health Partnership
Children's SMART	Postpartum Progress
Citizens for Substance Free Youth	Primary Care Coalition
County Overdose Prevention Plan	St. Mary's County License Beverage Association
Domestic Violence Coordinating Council	STAR/Sisters Together and Reaching
HC Drug Free	Suicide Awareness Board
Healthy Harford	Talbot Partnership for Alcohol and Other Drug Abuse Prevention
House of Ruth	The Center for Medical Technology Policy
Jesse's Paddle Organization	Tobacco and Cancer Coalition - Worcester County
Mental Health Association	Worcester County Warriors Against Opioid Use

APPENDIX E. HOSPITALS' FY 2016 FUNDING FOR NURSE SUPPORT PROGRAM I, DIRECT MEDICAL EDUCATION, AND CHARITY CARE

Hospital Name	Direct Medical Education (DME)	Nurse Support Program I (NSPI)	Charity Care in Rates	Total Rate Support
Meritus Medical Center	$0	$305,142	$4,323,873	$4,629,015
UMMC & Shock Trauma	$115,827,995	$1,498,576	$45,307,783	$162,634,354
Dimensions Prince Georges Hospital Center	$5,117,267	$267,282	$15,451,354	$20,835,903
Holy Cross Hospital	$2,708,039	$468,877	$22,196,553	$25,373,468
Frederick Memorial	$0	$339,661	$10,487,592	$10,827,253
UM Harford Memorial	$0	$53,719	$2,714,640	$2,768,359
Mercy Medical Center	$9,414,846	$489,187	$21,043,592	$30,947,625
Johns Hopkins Hospital	$108,442,934	$2,172,518	$32,624,031	$143,239,483
UM Shore Medical Dorchester	$0	$58,994	$406,423	$465,417
St. Agnes	$7,229,390	$410,191	$17,766,212	$25,405,792
LifeBridge Sinai	$14,784,200	$699,430	$6,287,935	$21,771,565
Bon Secours	$0	$129,714	$782,651	$912,365
MedStar Franklin Square	$9,890,754	$486,467	$5,710,667	$16,087,888
Adventist Washington Adventist	$0	$260,306	$18,531,753	$18,792,059
Garrett County Hospital	$0	$45,203	$2,308,692	$2,353,894
MedStar Montgomery General	$0	$167,893	$2,466,641	$2,634,534
Peninsula Regional	$0	$416,389	$8,413,535	$8,829,924
Suburban Hospital	$331,245	$289,287	$6,501,312	$7,121,843
Anne Arundel Medical Center	$0	$554,132	$4,636,381	$5,190,513
MedStar Union Memorial	$14,052,897	$415,164	$4,803,501	$19,271,563
Western Maryland Health System	$0	$317,899	$6,790,924	$7,108,823
MedStar St. Mary's Hospital	$0	$157,936	$1,403,612	$1,561,548
Johns Hopkins Bayview Medical Center	$23,141,000	$605,106	$13,491,671	$37,237,778
UM Shore Medical Chestertown	$0	$64,509	$526,810	$591,319
Union Hospital of Cecil County	$0	$157,914	$1,053,373	$1,211,287
Carroll Hospital Center	$0	$251,985	$1,596,917	$1,848,902
MedStar Harbor Hospital	$4,696,418	$205,146	$3,416,540	$8,318,105
UM Charles Regional Medical Center	$0	$144,786	$3,769,104	$3,913,890
UM Shore Medical Easton	$0	$187,483	$1,799,429	$1,986,913
UM Midtown	$3,073,957	$178,843	$10,196,092	$13,448,892
Calvert Hospital	$0	$120,604	$5,351,799	$5,472,403
Lifebridge Northwest Hospital	$0	$249,135	$3,573,557	$3,822,691
UM Baltimore Washington	$628,161	$393,182	$6,845,110	$7,866,453

Hospital Name	Direct Medical Education (DME)	Nurse Support Program I (NSPI)	Charity Care in Rates	Total Rate Support
GBMC	$5,237,160	$426,965	$2,603,763	$8,267,888
McCready	$0	$16,638	$392,686	$409,324
Howard County Hospital	$0	$281,806	$4,487,570	$4,769,375
UM Upper Chesapeake	$0	$157,472	$5,415,566	$5,573,038
Doctors Community	$0	$222,145	$11,635,983	$11,858,128
Dimensions Laurel Regional Hospital	$0	$118,865	$2,846,496	$2,965,361
Fort Washington Medical Center	$0	$48,566	$1,281,924	$1,330,490
Atlantic General	$0	$102,693	$3,759,190	$3,861,883
MedStar Southern Maryland	$0	$261,812	$2,196,073	$2,457,885
UM St. Joseph	$0	$362,416	$3,339,349	$3,701,765
Lifebridge Levindale	$4,088,269	$54,542	$383,646	$4,526,457
Holy Cross Germantown Hospital	$5,371,417	$0		$5,371,417
UM Rehabilitation and Ortho Institute	$0	$118,262	$1,507,076	$1,625,338
MedStar Good Samaritan	$0	$299,250	$3,426,984	$3,726,234
Adventist Rehab of Maryland	$0	$61,978	$0	$61,978
Sheppard Pratt	$0	$139,935	$0	$139,935
Adventist Behavioral Health Rockville	$2,415,214	$0	$0	$2,415,214
Mt. Washington Pediatrics	$0	$55,464	$0	$55,464
Adventist Shady Grove Hospital	$0	$383,323	$8,023,394	$8,406,717
Total	**$336,451,161**	**$15,674,793**	**$343,879,759**	**$696,005,714**

APPENDIX F. FY 2016 COMMUNITY BENEFIT ANALYSIS

Hospital Name	Number of Employees	Number of Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit W/Medicaid Expansion Expense	Total CB as % of Total Operating Expense	Total in Rates for Charity Care, DME, and NSPI*	Net CB minus Charity Care, DME, NSPI in Rates + ACA Expansion Expense	Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care
Calvert Hospital	1,329	243	$1,128,684,174	$16,485,245	1.5%	$5,472,403	$11,012,841	1.0%	$3,808,206
McCready	294	5	$14,968,260	$275,197	1.8%	$409,324	-$134,127	-0.9%	$185,796
Mt. Washington Pediatrics	674	2,346	$54,438,547	$1,484,992	2.7%	$55,464	$1,429,528	2.6%	$88,862
Ft. Washington	432	0	$42,405,282	$1,507,390	3.5%	$1,330,490	$176,900	0.4%	$914,689
GBMC	2,561	5,826	$402,046,322	$14,937,451	3.7%	$8,267,888	$6,669,562	1.7%	$2,007,183
Union Hospital of Cecil County	1,149	2,208	$152,850,972	$6,643,655	4.3%	$1,211,287	$5,432,368	3.6%	$899,826
UM Upper Chesapeake	0	2,128	$261,076,000	$12,076,222	4.6%	$5,573,038	$6,503,184	2.5%	$3,818,000
MedStar Montgomery General	1,158	0	$151,876,735	$7,099,282	4.6%	$2,634,534	$4,464,748	2.9%	$1,821,317
MedStar Southern Maryland	1,451	14,020	$242,526,804	$11,610,090	4.7%	$2,457,885	$9,152,205	3.8%	$2,691,523
Levindale	863	520	$72,413,402	$3,701,218	5.1%	$4,526,457	-$825,239	-1.1%	$1,443,083
Lifebridge Northwest Hospital	1,768	2,260	$233,286,000	$15,548,424	6.5%	$3,822,691	$11,725,733	5.0%	$3,524,100
MedStar Franklin Square	3,283	2,676	$508,064,432	$34,272,215	6.7%	$16,087,888	$18,184,327	3.6%	$5,147,191
Holy Cross Germantown	654	180	$86,826,724	$5,917,376	6.8%	$5,371,417	$545,959	0.6%	$2,382,942
UM Harford Memorial	0	912	$82,723,000	$5,869,284	7.0%	$2,768,359	$3,100,925	3.7%	$1,915,000
Carroll Hospital Center	1,988	2,080	$216,062,000	$15,567,400	7.2%	$1,848,902	$13,718,497	6.3%	$1,303,875
Meritus Medical Center	2,294	816	$299,130,713	$21,982,139	7.3%	$4,629,015	$17,353,124	5.8%	$4,903,600
UM Baltimore Washington	2,200	3,117	$330,823,000	$24,523,875	7.3%	$7,866,453	$16,657,422	5.0%	$5,655,016
LifeBridge Sinai	4,778	7,128	$714,926,000	$53,250,243	7.4%	$21,771,565	$31,478,678	4.4%	$5,452,000
Howard County Hospital	1,856	2,622	$250,602,000	$19,400,167	7.7%	$4,769,375	$14,630,791	5.8%	$3,560,370
Suburban Hospital	1,755	2,351	$271,382,000	$21,570,933	7.9%	$7,121,843	$14,449,089	5.3%	$3,294,000
MedStar St. Mary's Hospital	1,200	6,040	$149,998,897	$12,157,877	8.0%	$1,561,548	$10,596,329	7.1%	$1,508,919

Hospital Name	Number of Employees	Number of Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit W/Medicaid Expansion Expense	Total CB as % of Total Operating Expense	Total in Rates for Charity Care, DME, and NSPI*	Net CB minus Charity Care, DME, NSPI in Rates + ACA Expansion Expense	Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care
MedStar Good Samaritan	2,162	980	$302,367,777	$24,920,169	8.2%	$3,726,234	$21,193,935	7.0%	$3,308,833
MedStar Union Memorial	2,369	40	$424,392,626	$35,335,924	8.3%	$19,271,563	$16,064,362	3.8%	$4,012,263
Adventist Rehab of Maryland*	484	772	$38,791,987	$3,324,826	8.6%	$61,978	$3,262,848	8.4%	$964,421
Johns Hopkins Bayview Medical Center	3,398	1,035	$596,562,000	$52,422,558	8.7%	$37,237,778	$15,184,780	2.5%	$12,679,000
Sheppard Pratt	2,459	545	$213,531,372	$18,791,283	8.8%	$139,935	$18,651,348	8.7%	$6,451,134
Anne Arundel Medical Center	4,746	4,271	$531,698,000	$47,363,958	8.9%	$5,190,513	$42,173,445	7.9%	$3,486,700
Johns Hopkins Hospital	0	8,500	$2,173,349,000	$195,778,964	9.0%	$143,239,483	$52,539,481	2.4%	$22,047,000
Doctors Community	1,509	1,218	$186,693,541	$17,100,686	9.0%	$11,858,128	$5,242,558	2.8%	$12,200,284
Frederick Memorial	1,764	1,080	$330,320,000	$31,884,494	9.6%	$10,827,253	$21,057,242	6.4%	$11,277,000
Shady Grove*	2,037	10,080	$316,512,363	$30,571,076	9.6%	$8,406,717	$22,164,359	7.0%	$6,620,218
Garrett County Hospital	419	16	$42,622,790	$3,284,231	7.5%	$2,353,894	$930,336	2.2%	$2,316,474
UM St. Joseph	2,434	0	$330,061,000	$32,760,787	9.9%	$3,701,765	$29,059,022	8.8%	$3,488,000
MedStar Harbor Hospital	1,103	182	$190,376,563	$19,408,834	10.1%	$8,318,105	$11,090,729	5.8%	$2,995,264
UM Rehabilitation and Ortho Institute	625	520	$103,856,400	$10,662,155	10.2%	$1,625,338	$9,036,817	8.7%	$2,197,000
St. Agnes	2,805	0	$434,193,000	$46,549,340	10.6%	$25,405,792	$21,143,548	4.9%	$21,867,282
Peninsula Regional	2,829	361	$405,639,685	$43,315,440	10.7%	$8,829,924	$34,485,516	8.5%	$7,836,700
Atlantic General	930	101	$112,904,430	$12,786,633	11.3%	$3,861,883	$8,924,750	7.9%	$3,277,824
UM Shore Medical Dorchester	428	375	$39,677,059	$4,574,355	11.4%	$465,417	$4,108,938	10.4%	$499,553
UM Charles Regional Medical Center	979	1,048	$113,371,227	$13,457,175	11.8%	$3,913,890	$9,543,285	8.4%	$3,798,238
Holy Cross Hospital	3,555	4,431	$411,176,881	$53,488,786	12.9%	$25,373,468	$28,115,317	6.8%	$33,462,706
UM Shore Medical Easton	1,353	1,000	$174,850,678	$22,727,672	13.0%	$1,986,913	$20,740,759	11.9%	$1,575,225

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Hospital Name	Number of Employees	Number of Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit W/Medicaid Expansion Expense	Total CB as % of Total Operating Expense	Total in Rates for Charity Care, DME, and NSPI*	Net CB minus Charity Care, DME, NSPI in Rates + ACA Expansion Expense	Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care
Mercy Medical Center	3,915	2,617	$461,664,800	$60,092,759	13.0%	$30,947,625	$29,145,134	6.3%	$19,521,700
Bon Secours	697	7,033	$115,814,419	$16,364,154	14.0%	$912,365	$15,451,789	13.3%	$607,325
Western Maryland Health System	1,878	247	$314,069,685	$44,321,300	14.0%	$7,108,823	$37,212,478	11.8%	$9,670,307
UMMC	8,584	1,979	$1,445,705,000	$214,666,776	14.8%	$162,634,354	$52,032,422	3.6%	$28,945,000
Adventist Behavioral Health Rockville*	432	0	$35,253,036	$5,384,999	15.3%	$2,415,214	$2,969,785	8.4%	$1,866,300
Dimensions Prince Georges Hospital Center	0	0	$263,131,867	$46,449,141	17.7%	$20,835,903	$25,613,238	9.7%	$9,769,558
UM Shore Medical Chestertown	272	860	$48,488,291	$8,779,666	18.0%	$591,319	$8,188,347	16.9%	$407,715
Adventist Washington Adventist*	1,351	6,624	$217,955,646	$40,704,527	18.6%	$18,792,059	$21,912,468	10.1%	$14,800,908
UM Midtown	1,215	416	$191,264,500	$36,601,059	19.1%	$13,448,892	$23,152,167	12.1%	$9,787,000
Dimensions Laurel Regional Hospital	0	0	$95,998,834	$23,918,466	24.8%	$2,965,361	$20,953,106	21.8%	$2,869,600
Total	**86,655**	**113,808**	**$16,329,405,721**	**$1,523,672,867**	**9.3%**	**$696,005,714**	**$827,667,153**	**5.1%**	**$320,932,030**
Average	**1,699**	**2,189**	**$314,027,033**		**9.5%**			**6.2%**	**$6,171,770**

* The Adventist Hospital System requested and received permission to report its community benefit activities on a calendar year basis to more accurately reflect true activities during the community benefit cycle. The numbers listed in the “Total in Rates for Charity Care, DME, and NSPI*” column reflect the HSCRC's activities for FY 2015 and therefore are different from the numbers reported by the Adventist Hospitals.

APPENDIX G. FY 2016 HOSPITAL COMMUNITY BENEFIT AGGREGATE DATA

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
				Unreimbursed Medicaid Costs				
T99	Medicaid Assessments	0	0	$389,825,000		$333,349,117	$56,475,883	$56,475,883
				Community Health Services				
A10	Community Health Education	382,161	3,038,413	$20,338,261	$10,281,296	$2,256,680	$28,362,877	$18,081,581
A11	Support Groups	16,359	36,353	$1,169,208	$701,273	$38,618	$1,831,863	$1,130,590
A12	Self-Help	29,563	145,047	$1,249,291	$663,523	$356,920	$1,555,894	$892,371
A20	Community-Based Clinical Services	377,919	324,994	$12,706,209	$10,135,395	$9,841,016	$13,000,587	$2,865,193
A21	Screenings	36,882	81,415	$1,931,321	$1,034,008	$219,719	$2,745,610	$1,711,602
A22	One-Time/Occasionally Held Clinics	3,491	13,949	$271,189	$115,483	$48,051	$338,621	$223,138
A23	Free Clinics	37,374	40,476	$4,694,217	$2,290,034	$238,653	$6,745,598	$4,455,564
A24	Mobile Units	30,965	10,261	$1,344,251	$588,967	$1,173,897	$759,321	$170,354
A30	Health Care Support Services	269,924	204,933	$31,662,282	$14,511,490	$3,964,409	$42,209,362	$27,697,873
A40	Other	37,041	100,007	$4,210,910	$2,536,686	$1,204,900	$5,542,696	$3,006,010
A41	Other	18,569	29,038	$2,296,966	$1,501,723	$0	$3,798,689	$2,296,966
A42	Other	1,807	11,470	$228,348	$109,369	$2,584	$335,133	$225,764
A99	**Total**	**1,242,055**	**4,036,356**	**$82,102,454**	**$44,469,247**	**$19,345,448**	**$107,226,253**	**$62,757,005**
				Health Professions Education				
B1	Physicians/Medical Students	4,020,097	39,858	$334,666,432	$79,790,838	$125,011	$414,332,259	$334,541,421
B2	Nurses/Nursing Students	569,151	50,236	$24,198,696	$4,293,690	$289,080	$28,203,306	$23,909,616
B3	Other Health Professionals	340,101	51,710	$15,596,506	$3,613,821	$212,738	$18,997,589	$15,383,768
B4	Scholarships/Funding for Professional Education	6,763	1,324	$3,210,803	$97,933	$0	$3,308,736	$3,210,803
B50	Other	95,552	22,842	$3,961,970	$316,537	$37,383	$4,241,124	$3,924,587

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
B51	Other	22,652	9,184	$1,435,827	$3,685	$1,425,707	$13,805	$10,120
B52	Other	5,440	5,017	$213,093	$49,827	$76,244	$186,676	$136,849
B99	**Total**	**5,059,756**	**180,171**	**$383,283,328**	**$88,166,329**	**$2,166,163**	**$469,283,494**	**$381,117,165**
				Mission-Driven Health Services				
	Mission-Driven Health Services Total	**2,283,557**	**937,072**	**$566,171,842**	**$98,813,317**	**$172,236,829**	**$492,748,329**	**$393,935,012**
				Research				
D1	Clinical Research	59,261	2,629	$8,944,723	$1,630,787	$4,689,642	$5,885,867	$4,255,080
D2	Community Health Research	24,188	3,751	$1,825,497	$707,111	$132,299	$2,400,309	$1,693,198
D3	Other	27,642	18	$2,757,361	$111,669	$1,505,236	$1,363,795	$1,252,126
D99	**Total**	**111,091**	**6,398**	**$13,527,582**	**$2,449,567**	**$6,327,177**	**$9,649,972**	**$7,200,405**
				Financial Contributions				
E1	Cash Donations	1,285	25,803	$12,235,928	$317,295	$80,454	$12,472,769	$12,155,474
E2	Grants	0	36	$456,586	$101,434	$95,359	$462,661	$361,227
E3	In-Kind Donations	27,092	158,126	$7,887,385	$430,013	$975,812	$7,341,586	$6,911,573
E4	Cost of Fund Raising for Community Programs	4,439	7,553	$432,170	$118,205	$0	$550,375	$432,170
E99	**Total**	**32,816**	**191,518**	**$21,012,069**	**$966,947**	**$1,151,625**	**$20,827,391**	**$19,860,444**
				Community-Building Activities				
F1	Physical Improvements/Housing	5,972	303,759	$3,306,158	$2,740,897	$2,384,571	$3,662,484	$921,587
F2	Economic Development	12,694	3,356	$799,088	$423,187	$331,264	$891,011	$467,824
F3	Support System Enhancements	74,697	16,059	$3,112,778	$1,653,681	$960,646	$3,805,813	$2,152,132
F4	Environmental Improvements	10,308	814	$592,824	$234,923	$105,251	$722,496	$487,573
F5	Leadership Development/Training for Community Members	10,609	1,046	$404,895	$249,144	$0	$654,039	$404,895
F6	Coalition Building	23,959	11,743	$2,160,833	$1,085,032	$77,101	$3,168,764	$2,083,732

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
F7	Community Health Improvement Advocacy	30,728	9,567	$2,766,062	$1,571,136	$549	$4,336,649	$2,765,513
F8	Workforce Enhancement	74,361	80,696	$4,590,711	$2,659,975	$387,960	$6,862,726	$4,202,751
F9	Other	2,452	26,271	$292,930	$134,478	$22,975	$404,433	$269,955
F10	Other	7,710	84	$135,786	$95,339	$0	$231,125	$135,786
F99	**Total**	**253,490**	**453,394**	**$18,162,064**	**$10,847,792**	**$4,270,317**	**$24,739,540**	**$13,891,747**
	Community Benefit Operations							
G1	Dedicated Staff	98,925	1,492	$6,246,229	$3,858,166	$63,136	$10,041,258	$6,183,092
G2	Community health/health assets assessments	5,585	490	$854,836	$312,751	$23,717	$1,143,870	$831,119
G3	Other Resources	9,293	516	$1,599,814	$674,718	$42,370	$2,232,162	$1,557,444
G4	Other	5	34	$178	$129	$0	$307	$178
G99	**Total**	**113,808**	**2,531**	**$8,701,057**	**$4,845,763**	**$129,223**	**$13,417,597**	**$8,571,834**
	Charity Care							
	Total Charity Care	$320,932,030						
	Foundation-Funded Community Benefits							
J1	Community Services	13,262	37,364	$866,266	$92,612	$456,606	$502,273	$409,661
J2	Community Building	63,599	11,707	$2,836,577	$63,348	$1,809,265	$1,090,660	$1,027,312
J3	Other	1,020	618	$150,000	$0	$0	$150,000	$150,000
J99	**Total**	**77,881**	**49,689**	**$3,852,843**	**$155,961**	**$2,265,871**	**$1,742,933**	**$1,586,973**
	Total Hospital Community Benefits							
A	Community Health Services	1,242,055	4,036,356	$82,102,454	$44,469,247	$19,345,448	$107,226,253	$62,757,005
B	Health Professions Education	5,059,756	180,171	$383,283,328	$88,166,329	$2,166,163	$469,283,494	$381,117,165
C	Mission Driven Health Care Services	2,283,557	937,072	$566,171,842	$98,813,317	$172,236,829	$492,748,329	$393,935,012
D	Research	111,091	6,398	$13,527,582	$2,449,567	$6,327,177	$9,649,972	$7,200,405
E	Financial Contributions	32,816	191,518	$21,012,069	$966,947	$1,151,625	$20,827,391	$19,860,444

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
F	Community Building Activities	253,490	453,394	$18,162,064	$10,847,792	$4,270,317	$24,739,540	$13,891,747
G	Community Benefit Operations	113,808	2,531	$8,701,057	$4,845,763	$129,223	$13,417,597	$8,571,834
H	Charity Care	0	0	$320,932,030	$0	$0	$320,932,030	$320,932,030
J	Foundation Funded Community Benefit	77,881	49,689	$3,852,843	$155,961	$2,265,871	$1,742,933	$1,586,973
T99	Medicaid Assessments	0	0	$389,825,000		$333,349,117	$56,475,883	$56,475,883
K99	**Total Hospital Community Benefit**	**9,174,456**	**5,857,129**	**1,807,570,268**	**250,714,924**	**541,241,771**	**1,517,043,421**	**1,266,328,498**

	Total Operating Expenses	**$16,329,405,721**
	% Operating Expenses w/ Indirect Costs	**9.3%**
	% Operating Expenses w/ o Indirect Costs	**7.8%**