Maryland Hospital Community Benefits Report
FY 2013

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INTRODUCTION

Each year, the Health Services Cost Review Commission ("Commission" or "HSCRC") collects community benefit information from individual hospitals to compile into a publicly available statewide Community Benefit Report ("CBR"). This document contains summary information for all submitting Maryland hospitals for FY 2013. Past and current year's CB reports submitted by the individual hospitals are available on the Commission's website.

Background

Section 501(c)(3) of the Internal Revenue Service Code exempts organizations that are organized and operated exclusively for, among other things, religious, charitable, scientific, or educational purposes. As a result of their tax exempt status, nonprofit hospitals receive many benefits. They are generally exempted from federal income and unemployment taxes as well as from state and local income, property, and sales taxes. In addition, they have the ability to raise funds through tax-deductable donations and tax-exempt bond financing. Originally, the IRS permitted hospitals to qualify as "charitable" if they provided charity care to the extent of their financial ability to do so. However in 1969, Rev. Ruling 69-545 issued by the IRS broadened the meaning of "charitable" from charity care to the "promotion of health", stating':

> "[T]he promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all the members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community"

Thus was created the "community benefit standard" for hospitals to qualify for tax exempt status.

In March 2010, Congress passed the Patient Protection and Affordable Care Act ("ACA"). Under the ACA, every § 501(c)(3) hospital, whether independent or in a system, must conduct a community health needs assessment at least once every three years in order to maintain its tax-exempt status and avoid an annual penalty of up to $50,000. The first needs assessment was due by the end of the hospital's fiscal year 2013. Each community health needs assessment must take into account input from persons who represent the broad interest of the community served, including those with special knowledge or expertise in public health, and the assessment must be made widely

available to the public. An implementation strategy describing how a hospital will meet the community's health needs must be included, as well as a description of what the hospital has done historically to address its community needs. Furthermore, the hospital must identify any needs that have not been met by the hospital and why these needs have not been addressed. Tax-exempt hospitals must report this information on Schedule H of the IRS 990 forms.

The Maryland CBR process was adopted by the Maryland General Assembly in 2001 (Health-General Article §19-303 Maryland Annotated Code), with FY 2004 set as the first data collection period. The Commission worked with the Maryland Hospital Association ("MHA") and interested hospitals, local health departments, and health policy organizations and associations on the details and format of the community benefit report. In developing the format for data collection, the group drew heavily on the experience of the Voluntary Hospitals of America ("VHA") community benefit process which possessed, at the time, over 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 the FY 2004 data to the Commission in January 2005. The Commission's first CBR, detailing FY 2004 data, was published in July 2005.

The HSCRC continues to work with the MHA, public health officials and individual hospitals to further improve the reporting process and to refine the definitions as needed. The data collection process offers an opportunity for each Maryland non-profit, acute care hospital to critically review and report its activities designed to benefit the community it serves.

The Fiscal Year 2013 report represents the HSCRC's tenth year of reporting on Maryland hospital community benefit data.

Definition of Community Benefits

Maryland law defines a "community benefit" (CB) as an activity that is intended to address community needs and priorities primarily through disease prevention and improvement of health status, including:

- Health services provided to vulnerable or underserved populations;
- Financial or in-kind support of public health programs;
- Donations of funds, property, or other resources that contribute to a community priority;
- Health care cost containment activities; and

- Health education screening and prevention services.

As evidenced in the individual reports, Maryland hospitals provide a broad range of health services to meet the needs of their communities, often receiving partial or no compensation. These activities, however, are expected from Maryland's 46 acute, not-for-profit hospitals as a result of the tax exemptions they receive.

ANALYSIS

FY 2013 Data Reporting Highlights

The reporting period for this CBR is July 1, 2012 – June 30, 2013. Hospitals submitted their individual community benefit reports to the HSCRC by December 15, 2013 using audited financial statements as the source for calculating costs in each of the community benefit categories. Of the 48 not-for- profit hospitals in Maryland, 46 Community Benefit Reports were submitted. There are two hospital systems, Shore Health System and Upper Chesapeake Hospital, which submitted Community Benefit Reports covering both hospitals in their system. Shore Health submitted a single Community Benefit Report covering both Easton and Dorchester Hospitals. Upper Chesapeake Hospital submitted a single Community Benefit Report covering both Upper Chesapeake Medical Center and Harford Memorial Hospital.

As shown in Table I below, in FY2013, Maryland hospitals provided approximately $1.5 billion dollars in total community benefit activities in FY 2013 (up from $1.4 billion in FY 2012). This total is comprised of $518.2 million in Charity Care, $412.9 million in Health Professions Education, $379.0 million in Mission Driven Health Care Services, $ 82.7 million in Community Health Services, $56.4 million in Unreimbursed Medicaid Cost, $20.0 million in Financial Contributions, $ 16.9 million in Community Building Activities, $8.2 million in Community Benefit Operations, $ 7.9 million in Research activities, and $1.9 million in Foundation Funded Community Benefits[1].

[1] 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 hospitals reported direct costs.

Table I –Total Community Benefit

Community Benefit Category	Number of Staff Hours	Number of Encounters	Net Community Benefit Expense	Percent of Total CB Expenditures	Net Community Benefit Expense Less: Rate Support	Percent of Total CB Expenditures w/o Rate Support
Unreimbursed Medicaid Cost	0	0	$ 56,475,876	3.8%	$ 56,475,876	7.9%
Community Health Services	949,714	18,964,608	$ 82,744,997	5.5%	$ 82,744,997	11.6%
Health Professions Education *	6,380,270	238,664	$ 412,874,329	27.4%	$ 83,356,744	11.7%
Mission Driven Health Services	2,315,237	870,142	$ 380,227,201	25.3%	$380,227,201	53.4%
Research	64,052	5,932	$ 7,949,004	0.5%	$ 7,949,004	1.1%
Financial Contributions	44,652	216,700	$ 20,051,769	1.3%	$ 20,051,769	2.8%
Community Building	152,743	675,369	$ 16,886,257	1.1%	$ 16,886,257	2.4%
Community Benefit Operations	86,836	2,121	$ 8,180,001	0.5%	$ 8,180,001	1.1%
Foundation	48,532	11,987	$ 1,930,355	0.1%	$ 1,930,355	0.3%
Charity Care *	0	0	$ 518,234,532	34.4%	$ 54,624,388	7.7%
Total	10,042,036	20,985,523	$ 1,505,554,322	100.0%	$ 712,426,593	100.0%

(*) Indicates category adjusted for rate support (GME, NSPI, Charity Care)

In Maryland, the costs of uncompensated care (both charity care and bad debt) and graduate medical education are built into rates for which hospitals are reimbursed by all payers, including Medicare and Medicaid. Additionally, the HSCRC includes amounts in rates for hospital nurse support programs provided at Maryland hospitals. These costs are, in essence, "passed-through" to the purchasers and payers of hospital care. To be consistent with IRS form 990 requirements and to avoid accounting confusion among programs that are not funded in part by hospital rate setting (unregulated), the HSCRC requested that hospitals not include revenue provided in rates as offsetting revenue on the CBR worksheet. Attachment III details the amounts that are included in rates and funded by all payers for charity care, direct graduate medical education, and the nurse support program in Fiscal Year 2013.

As noted, the HSCRC includes a provision in hospital rates for uncompensated care; this includes charity care (eligible for inclusion as a community benefit by Maryland hospitals in their CBRs) and bad debt (not considered a community benefit). As detailed in Attachment III, $462.6 million in charity care was provided through Maryland hospital rates in FY 2013 that was funded by all payers. When offset against the hospital reported amount of $517.6 million in charity care, the net amount provided by the hospitals is $55.0 million.

Also as noted, another social cost funded in Maryland's rate-setting system in the cost of graduate medical education, generally for interns and residents trained in Maryland hospitals. Included in graduate medical education costs are the direct costs (Direct Medical Education or "DME"), which constitute wages and benefits of residents and interns, faculty supervisory expenses, and allocated overhead. The Commission utilizes its annual cost report to quantify the DME costs of Physician training programs at Maryland hospitals. In FY 2013, DME costs totaled $316.2 million.

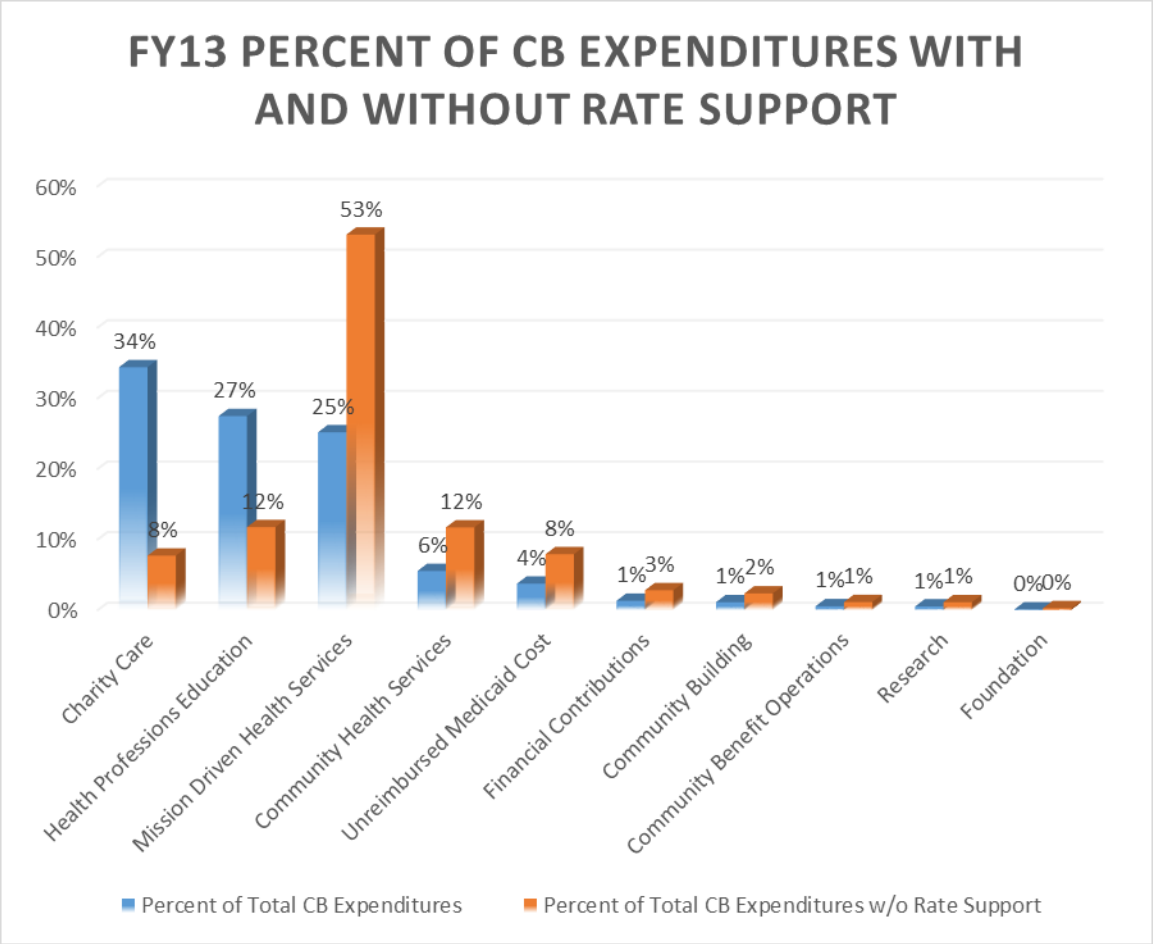
The Commission's Nurse Support Program I (NSPI) is aimed at addressing the short and long-term nursing shortage impacting Maryland hospitals. In FY 2013, $13.3 million was provided in hospital rate adjustments for NSPI. For further information about funding provided to specific hospitals, please see Attachment III.

When the reported community benefit costs are offset by rate support, the net community benefit provided by Maryland hospitals in FY 2013 was $712.4 million, or 5.2% of the total hospital operating expenses. This is up from the $651.6 million in net benefits provided in FY 2012 which totaled 4.82% of hospitals' operating expenses. Please see the chart in Attachment II for more detail.

For additional detail and a description of subcategories under each community benefit category, please see the chart under Attachment I – Aggregated Hospital CBR Data.

The distribution of expenses by category is significantly impacted by offsets in rates. Expenditures in each category as a percentage of total expenditures (see Table II below*)* Charity Care, Health Professions Education and Mission Driven Health Services represent the majority of the expenses at 34%, 27%, and 25%, respectively. However, when considering the expenditures without amounts provided in rates, the configuration changes significantly, moving Mission Driven Health Services (subsidized health services) into the largest category with 53%. (See Table II) Community Health Services and Health Professions Education follow each representing 12% of expenditures, respectively.

Table II –% of Expenditure by Category



Utilizing the data reported, Attachment II of the FY 2013 CB Analysis compares hospitals on the total amount of community benefits reported, the amount of community benefits that are recovered through HSCRC approved rates (charity care, direct medical education, and nurse support), and the number of staff and staff hours dedicated to the community benefit operations. On average, in FY 2013, 1,848 staff hours were dedicated to CB Operations. This is up 24% from last year's 1,491 staff hours. There are 4 hospitals reporting zero staff hours dedicated to CB Operations. The HSCRC continues to encourage hospitals to incorporate CB Operations into their overall strategic planning.

The total amount of community benefit expenditures as a percentage of total operating expenses ranges from 24.06% to 3.12% with the average percentage being 11.12%. This has increase from FY 2012's average of 10.06%. There are 23 hospitals that report providing benefits in excess of 10% of their operating expenses, as compared with twenty in FY 2012. Another fifteen hospitals exceed 7.5%.

FY 2013 Narrative Reporting Highlights

In FY 2013, hospitals were again asked to respond to narrative questions regarding their CB programs. The questions were developed, in part, to provide a standard reporting format for all hospitals. This uniformity not only provided readers of the individual hospital reports with more information than was previously available, but also allowed for comparisons across hospitals. The narrative guidelines were aligned, wherever possible, with the IRS form 990, schedule H, in an effort to provide as much consistency as is practicable in reporting on the State and Federal levels.

The HSCRC also considers the narrative guidelines to be a mechanism for assisting hospitals in critically examining their CB programs. Any examination of the effectiveness of major program initiatives should help hospitals determine which programs are achieving the desired results and which are not.

Through the hospitals' Community Health Needs Assessments (CHNA) a multitude of health concerns were identified. The top health needs consistently identified in the CHNAs include heart disease, obesity, behavioral/mental health/substance abuse, diabetes, access to care, and cancer. Many hospitals chose to address needs which align with the Maryland State Health Improvement Process's (SHIP) and/or the U.S. Department of Health and Human Services (DHHS) Healthy People 2020 initiative. SHIP provides a framework for continual progress toward a healthier Maryland. The SHIP includes 40 measures in five focus areas that represent what it means for Maryland to be healthy. Healthy People 2020, launched in December 2010, is the DHHS's 10 year plan for improving the health of all Americans

Hospitals were asked to include a list of unmet health needs which were identified through the most recent community health needs assessment, but which remain unaddressed due to a variety of circumstances. The most prevalent unmet health need noted in the FY 2013 was behavioral/mental health/substance abuse. This was also the most prevalent unmet need in FY 2012. Other unmet health needs, consistently identified were transportation, cancer, safe housing, and dental health. Some hospitals indicated these needs were being met by other community organizations as well as a lack of expertise/infrastructure/funding at the hospital as reasons for not addressing the identified needs.

The evaluation tool, resulting from the HSCRC advisory group was again used to evaluate hospitals' Community Benefit Narrative Reports. The group of evaluators consisted of three individuals, a representative of the HCSRC, a representative of the Maryland Hospital Association, and a public health official from the Delmarva foundation. FY 2013 showed little improvement in the narrative reporting process. The total points available were 209. Of the 47 hospitals evaluated, the average score was 192.1 or 92%. No submissions earned 100%, the top score was 207 points or 99.2%, and the lowest score was 125 points or 60%.

The section of the narrative report that lost most points on average was Section II, the Community Health Needs Assessment. According to the reporting instructions the CHNA must include a description of the community served by the hospital and how it was determined, the process and methods used to conduct the assessment, the CHNA and input collaborators identified by name and title, gaps in information, broad community input, a list of prioritized needs, the process and criteria used to prioritize the identified needs, and a description of the existing resources to meet the needs. The evaluators found numerous gaps in alignment of the actual reports with the above instructions.

FY2004 – FY2013 TEN YEAR SUMMARY

Fiscal Year 2013 marks the tenth year since the inception of the Community Benefit Report. In FY 2004, CB expenses represented $586.5 million or 6.9% of operating expenses. In FY 2013, CB expenses represented $1.5 billion or 11% of operating expenses. As Maryland Hospitals have increasingly focused on implementation of cost and quality improvement strategies, an increasing percentage of operating cost has been directed toward CB initiatives.

The reporting requirement for revenue offsets and rate support has changed since the inception of the CB report in FY 2004. For consistency purposes, the below charts

graphically represent Community Benefit Expense from FY2008 – FY2015. Table III (A & B) below represent the trend of CB expense in total and net of rate supports. On average, approximately 50% of the expenses have been reimbursed through the rate setting system.

Table III A - FY2008 – FY2013 Expenditures Total and Net of Rate Support

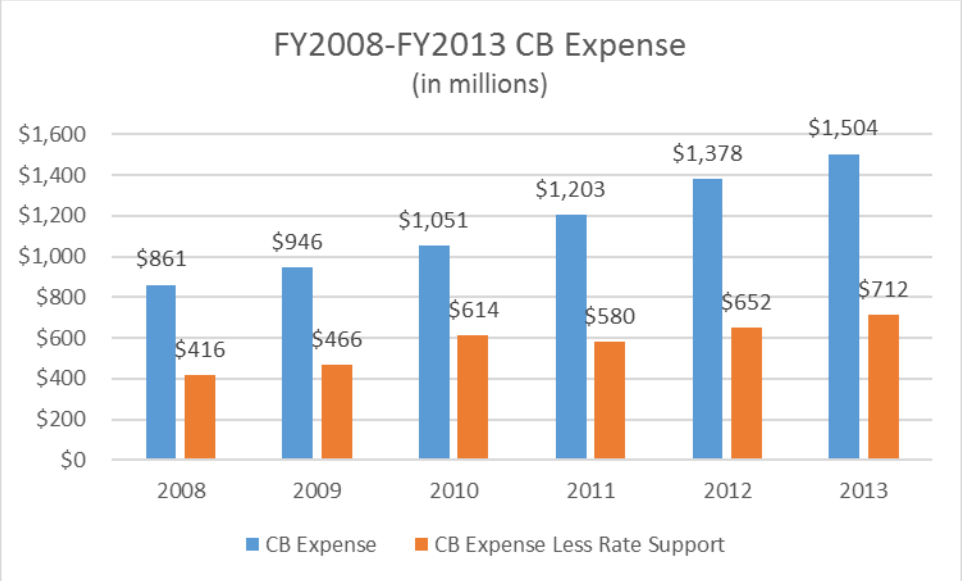
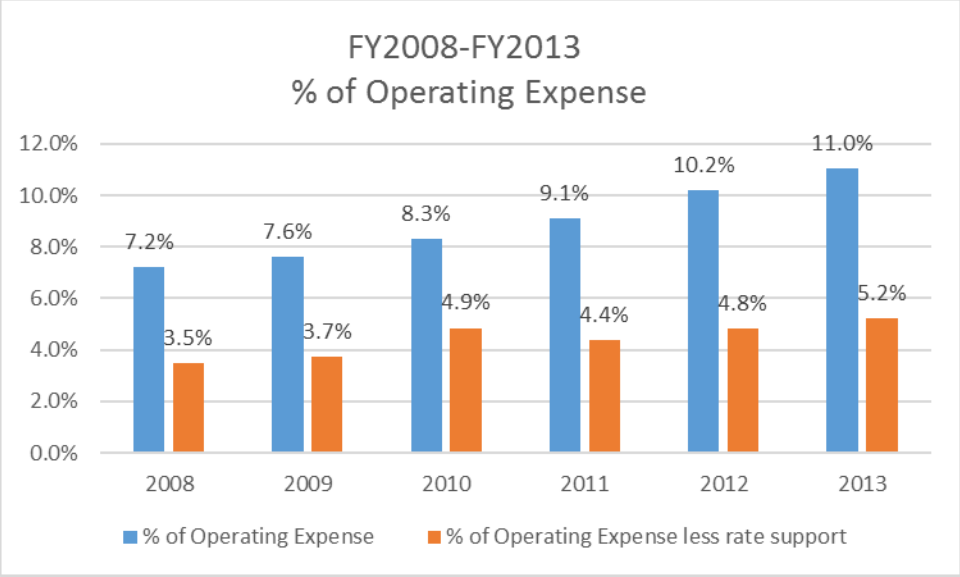


Table III A - FY2008 – FY2013 % Expenditures Total and Net of Rate Support



Maryland Hospitals' commitment to community benefits continues to grow when considered on either gross expenditure basis or when offsetting for amounts that are included in hospital rates as a result of Commission policy. These amounts do, however, include restricted grants that are provided to hospitals for community benefit related activities. The Internal Revenue Service has recently changed its rules to exclude or offset restricted grants and contributions the hospital uses to provide a community benefit. Staff is interested to observe how this new policy might impact the amount of dollars reported in future community benefit reports. With the State's drive toward population health and achieving the three-part aim, Commission staff will also continue to monitor the extent to which hospitals are making their community benefit mission part of their overall hospital strategic planning, and how they are collaborating with other hospitals, state and local health departments and policy makers, and other key community stakeholders on providing appropriate services that benefit people in the communities that they serve.