STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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489th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
June 6, 2012

EXECUTIVE SESSION
12:30 p.m.

1. **Waiver Issues**
2. **Legislative Audit**

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
1:00 p.m.

1. **Review of the Executive Session and Public Meeting Minutes of the May 2, 2012 Meeting**

2. **Executive Director's Report**

3. **Docket Status – Cases Closed**

   None

4. **Docket Status – Cases Open**

   2157N – Levindale Hospital
   2158N – Civista Medical Center
   2159N – Civista Medical Center
   2160N – Maryland General Hospital
   2161A – Johns Hopkins Health System
   2162A – Johns Hopkins Health System

5. **Final Recommendation on Variables for the Uncompensated Care Calculation**

6. **Final Recommendation on FY 2013 NSPII Competitive Institutional Grants**

7. **Review of Previous Five-year Cycle of Nurse Support Program I (NSPI), and Draft Recommendation on Continuance of, and Future Modifications to, NSPI**

8. **Draft Recommendation regarding FY 11 Averted Bad Debt Reconciliation, and Reconciliation Policy beginning FY 2012**

9. **Report on the Status of FY 13 Medicaid Assessment, and Hospital-related Cost Containment Measures**

10. **FY 2011 Community Benefit Report, and Changes to Reporting Requirements for the FY 2012 and FY 13 Community Benefit Report and Narrative**

11. **Legal Report**

12. **Hearing and Meeting Schedule**

H.S.C.R.C's CURRENT LEGAL DOCKET STATUS (OPEN)

AS OF MAY 24, 2012

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2157N	Levindale Hospital	4/20/2012	6/20/2012	9/17/2012	Rebundled Rates	CK	OPEN
2158N	Civista Medical Center	5/7/2012	6/6/2012	10/4/2012	HYP	CK	OPEN
2159N	Civista Medical Center	5/7/2012	6/6/2012	10/4/2012	ORC	CK	OPEN
2160N	Maryland General Hospital	5/15/2012	6/14/2012	10/12/2012	CHR,RDS,REC	GS	OPEN
2161A	Johns Hopkins Health System	5/16/2012	N/A	N/A	ARM	DNP	OPEN
2162A	Johns Hopkins Health System	5/16/2012	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF	*	**COST REVIEW COMMISSION**
LEVINDALE HEBREW GERIATRIC	*	**DOCKET: 2012**
CENTER AND HOSPITAL	*	**FOLIO: 1967**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2157N**

Staff Recommendation

June 6, 2012

Introduction

On April 25, 2012, Levindale Hebrew Geriatric Center and Hospital ("Hospital") submitted a partial rate application to the Commission requesting a rebundled rate for Emergency Services (EMG), Same Day Surgery (SDS), Operating Room (OR), Operating Room Clinic (ORC), Anesthesiology (ANS), Electroencephalography (EEG), Radiology-Therapeutic (RAT), Nuclear Medicine (NUC), CT Scanner (CAT), Interventional Radiology/Cardiovascular (IRC), and Magnetic Resonance Imaging (MRI) services. The Hospital has a growing population that is in need of these services that are not provided at the Hospital, but rather are provided at Sinai Hospital, which is located in close proximity to the Hospital. The Hospital is requesting Sinai Hospital of Baltimore (Sinai) rates for these services. The Hospital also is requesting a new Admissions Rate (ADM) based on the lower of a per admission rate based on its costs and volumes, or a per admission rate based on the statewide median for this service. The effective date for these services is July 1, 2012.

Staff Evaluation

Under COMAR 10.37.03.09, an approved rebundled rate must be equal to or less than the statewide median or price standard as developed by staff. Hence, staff compared the statewide median with the Sinai rate for EMG, SDS, OR, ORC, ANS, EEG, RAT, NUC, CAT, IRC and MRI services.

Also, to determine if the Hospital's new ADM rate should be set at the statewide median or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission all cost and statistical data for ADM services for FY 2012. Based on information received, it was determined that the ADM rate based on the Hospital's actual data would be $1,067 per admission, while the statewide median rate for ADM services is $136.46 per admission.

Recommendation

After reviewing the Hospital's application and information submitted to the Commission, the staff recommends as follows:

1. That COMAR 10.37.10.07 requiring that rate applications be filed 60 days before the opening of a new service be waived;
2. That a new ADM rate of $136.46 per admission be approved effective July 1, 2012;
3. That an ANS rate of $2.12, per minute, the Sinai rate, be approved effective July 1, 2012;
4. That a CAT rate of $6.58 per RVU, the statewide median, be approved effective July 1, 2012;
5. That an EEG rate of $11.91 per RVU, the statewide median be approved effective July 1,

2012;

6. That an EMG rate of $39.96 per RVU, the statewide median, be approved effective July 1, 2012;

7. That an IRC rate of $63.86 per RVU, the statewide median, be approved effective July 1, 2012;

8. That a MRI rate of $37.93 per RVU, the Sinai rate, be approved effective July 1, 2012;

9. That a NUC rate of $12.97 per RVU, the Sinai rate, be approved effective July 1, 2012;

10. That an OR rate of $29.25 per minute, the statewide median, be approved effective July 1, 2012;

11. That an ORC rate of $14.23 per minute, the statewide median, be approved effective July 1, 2012;

12. That a RAT rate of $20.19 per RVU, the Sinai rate, be approved effective July 1, 2012;

13. That a SDS rate of $594.27 per patient, the statewide median, be approved effective July 1, 2012

14. That ANS, CAT, EEG, EMG, IRC, MRI, NUC, OR, ORC, RAT and SDS as rebundled services not be rate realigned; and

15. That the ADM rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

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IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF THE	*	**COST REVIEW COMMISSION**
CIVISTA	*	**DOCKET: 2012**
MEDICAL CENTER	*	**FOLIO: 1968**
LA PLATA, MARYLAND	*	**PROCEEDING: 2158N**

Staff Recommendation

June 6, 2012

Introduction

On May 8, 2012, Civista Medical Center ("Hospital") submitted a partial rate application to the Commission requesting a rate for Hyperbaric Chamber (HYP) services. The Hospital is requesting the lower of a per hour of treatment rate based on its costs and volumes, or a per hour of treatment based on the statewide median for this service. The effective date for this service is July 1, 2012.

Staff Evaluation

To determine if the Hospital's HYP rate should be set at the statewide median or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission all projected cost and statistical data for HYP services for FY 2013. Based on information received, it was determined that the HYP rate based on the Hospital's projected data would be $563.51 per hour of treatment, while the statewide median rate for HYP services is $299.66 per hour of treatment.

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That COMAR 10.37.10.07 requiring that rate applications be filed 60 days before the opening of a new service be waived;
2. That an HYP rate of $299.66 per hour of treatment be approved effective July 1, 2012;
3. That no change be made to the Hospital's charge per episode standard for HYP services; and
4. That the HYP rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

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IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF	*	**COST REVIEW COMMISSION**
CIVISTA	*	**DOCKET: 2012**
MEDICAL CENTER	*	**FOLIO: 1969**
LA PLATA, MARYLAND	*	**PROCEEDING: 2159N**

Staff Recommendation

June 6, 2012

Introduction

On May 8, 2012, Civista Medical Center (the "Hospital") submitted a partial rate application to the Commission requesting a rate for Operating Room Clinic (ORC) services. The Hospital is requesting the lower of a per minute rate based on its costs and volumes, or a per minute rate based on the statewide median for this service.

Staff Evaluation

To determine if the Hospital's ORC rate should be set at the statewide median or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission all projected cost and statistical data for ORC services for FY 2013. Based on information received, it was determined that the ORC rate based on the Hospital's projected data would be $17.05 per minute, while the statewide median rate for ORC services is $14.23 per minute.

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That COMAR 10.37.10.07 requiring that rate applications be filed 60 days before the opening of a new service be waived;
2. That an ORC rate of $14.23 per minute be approved effective July 1, 2012;
3. That no change be made to the Hospital's charge per episode standard for ORC services; and
4. That the ORC rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

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IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2012**
SYSTEM	*	**FOLIO:**	**1971**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2161A**

Staff Recommendation

June 6, 2012

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed an application with the HSCRC on May 15, 2012 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for participation in a global rate arrangement for solid organ and bone marrow transplant, and cardiovascular services with Blue Cross Blue Shield Blue Distinction Centers for Transplants for a period of one year beginning May 1, 2012.

II. OVERVIEW OF APPLICATION

The contract will be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the new global rates was developed utilizing historical charges for patients receiving solid organ and bone marrow transplants at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Since the format utilized to calculate the case rate, i.e., historical data for like cases, has been utilized as the basis for other successful transplant arrangements in which the Hospitals are currently participating, staff believes that the Hospitals can

achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission: 1) waive the requirement that alternative applications be filed 30 days before the proposed effective date; 2) approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for a one year period commencing May 1, 2012. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2012**
SYSTEM	*	**FOLIO:**	**1972**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2162A**

Staff Recommendation

June 6, 2012

I. INTRODUCTION

On May 16, 2012, the Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval from the HSCRC to continue participation in a renegotiated global rate arrangement for cardiovascular procedures with the Coventry Health Care of Delaware, Inc. for international patients only. The Hospitals request that the Commission approve the arrangement for one year effective July 1, 2012.

II. OVERVIEW OF APPLICATION

The Hospitals requested and received a 90-day extension of the original approval period (May 1, 2011 to April 30, 2012) in order to provide time to renegotiate the arrangement.

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payment, disbursing payments to

the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

After review, staff is satisfied that the Hospitals can achieve favorable performance under the renegotiated arrangement. Staff also found that the experience under the prior arrangement was favorable for the last year.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular services for one year beginning July 1, 2012. The Hospitals must file a renewal application annually for continued participation, with approval contingent upon a favorable evaluation of performance.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document will formalize the understanding between the Commission and the Hospitals, and will include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, and confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

Final Recommendation on Changes to the Uncompensated Care Regression Model Outpatient Variables

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
410-764-2605

June 6, 2012

This recommendation was approved by the Commission on June 6, 2012.

Introduction

The purpose of this paper is to recommend for Commission approval changes to the outpatient variables used in the uncompensated care regression model when setting prospective rates. This recommendation is a final proposal and is ready for Commission action today.

As stated in the staff's Draft Recommendation of last month, the HSCRC's provision for uncompensated care in hospital rates is one of the hallmarks of rate regulation in Maryland. Uncompensated care includes bad debt and charity care. By recognizing reasonable levels of bad debt and charity care in hospital rates, the system enhances access to hospital care for those citizens who cannot pay for care. The uncompensated care provision in rates is applied prospectively and is meant to be predictive of actual uncompensated care costs in a given year. As a component of the uncompensated care methodology, the HSCRC uses a regression methodology as a vehicle to predict actual uncompensated care costs in a given year.

The uncompensated care methodology has undergone substantial changes over the years since it was initially established, including changes to the variables used in the predictive regression and the funding through pooling. The most recent version of the uncompensated care policy was adopted by the Commission on July 6, 2011 to accommodate a new approach to the Charity Care Adjustment.

With the HSCRC's collection of more robust outpatient data over the last three years, this recommendation proposes to change two of the variables used in the uncompensated care predictive regression as discussed below.

This recommendation does not modify the overall uncompensated care model, other methodologies associated with the calculation of uncompensated care, the allocation of uncompensated care in rates, the charity care adjustment, nor does this recommendation alter the policies regarding uncompensated care pooling.

The Uncompensated Care Model

Under the current policy, HSCRC staff compute the amount of uncompensated care in rates as follows:

1. Compute a three-year moving average for uncompensated care for each hospital
2. Use the most recent three years of data to compute the uncompensated care regression (while adding "dummy" variables for each year)
3. Generate a predicted value for the hospital's uncompensated care rate based on the last available year of data
4. Compute a 50/50 blend of the predicted and three-year moving average as the hospital's amount in rates
5. Calculate the statewide amount of uncompensated care in rates from this process, and generate the percentage difference between the preliminary amount in rates and the last year of actual experience

6. Multiply the percentage difference (step 5) by the hospital's preliminary uncompensated care rate (step 4) to get adjusted rates that tie to the State's last year of actual UCC experience (this is referred to as the Revenue Neutrality Adjustment)
7. Take the results (step 6) by hospital and make the charity care adjustments to them (Charity Care Adjustment is calculated as 20% of the deviation of Expected Rate from Actual Charity Care).

HSCRC staff use the result of the hospital's uncompensated care rate in the calculation of the 100 percent statewide uncompensated care pool for the next fiscal year.

Current Variables Used in the Uncompensated Care Regression

Within the uncompensated care model, the uncompensated care regression--Step 2 in the model described above--estimates the relationship between a set of explanatory variables and the rate of uncompensated care observed at each hospital as a percentage of gross patient revenue. Under the current policy, HSCRC staff includes the following as explanatory variables:

- Inpatient
    - Variable 1: The proportion of a hospital's total charges from inpatient non-Medicare admissions through the emergency department
    - Variable 2: The proportion of a hospital's total charges from inpatient Medicaid, self-pay, and charity cases
- Outpatient
    - Variable 3: The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits to the emergency department
    - Variable 4: The proportion of a hospital's total charges from outpatient charges

Discussions Surrounding the Outpatient Variables used in the Regression Model

When the Commission adopted the variables used in the regression model at its May 2, 2007 public meeting, the Johns Hopkins Health System and Mercy Medical Center commented to Commission staff that the outpatient variable, "the proportion of a hospital's total charges from outpatient services" (Variable 4, above), did not adequately capture the true measure of the outpatient poor population at many Maryland hospitals. The commentators contended that while the variable was statistically significant in helping to explain the overall uncompensated care level across all hospitals, it also inadvertently penalized hospitals with invariably high outpatient emergency room visits, but whose proportion of hospital's total charges from outpatient services appeared to be relatively small. The commentators attributed this to the fact that the Commission did not collect comprehensive outpatient data from hospitals. At that time, the only outpatient datasets collected by the Commission were ambulatory care and ambulatory surgery data.

The Commission began the collection of comprehensive outpatient data from Maryland hospitals under its jurisdiction effective July 1, 2007, including emergency department visit data. From the inception of this enhanced data collection effort, Commission staff intended to reevaluate Variable 4 ("the proportion of a hospital's total charges from outpatient services") as an

outpatient measure in the regression model. Commission staff understands that outpatient uncompensated care is due partly to high uncollectable copayments and coinsurance associated with certain outpatient services such as the emergency department and clinic visits.

With FY 2011 outpatient data, Commission staff now has available the three consecutive and complete years of outpatient data needed to reevaluate the outpatient variables used in the regression model to predict the reasonable levels of bad debt and charity care in hospital rates.

Over the past few months the Financial Technical Issues Task Force of the Maryland Hospital Association (MHA) and Commission staff has been working independently on a range of possible measures to replace the current outpatient variables in the regression model. On February 14, 2012, the MHA representatives met with Commission staff to discuss the findings.

Based on that meeting and subsequent review of the regression predictive variables, MHA representatives and Commission staff agree to recommend that the Commission replace both outpatient regression variables (Variables 3 and 4). We suggest that in the regression model the Commission:

- Variable 3:
    - Remove: The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits to the emergency department
    - Replace with: The proportion of a hospital's total charges from outpatient non-Medicare emergency department charges
- Variable 4:
    - Remove: The proportion of a hospital's total charges from outpatient services
    - Replace with: The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits

Impact of the Changed Uncompensated Care Regression Model Outpatient Variables

Commission staff considers the change to the outpatient variables to be an improvement to the current methodology, conceptually, statistically, and analytically. The change incorporates newly available data to better predict actual uncompensated care in the system. Updating the outpatient variables is especially important now with the recent shifts of hospital services from the inpatient to the outpatient setting.

These recommended changes to the outpatient regression variables do not alter the total prospective uncompensated care dollars built into rates across the system. Instead, these variable changes result in an improved distribution of that revenue among hospitals in the rate setting system.

Exhibit 1 shows the results of a preliminary calculation of uncompensated care rates for FY 2013 with the regression model Variables 3 and 4 replaced. Exhibit 2 provides a summary of the preliminary results from the model with the charity care adjustment. Exhibit 3 provides a

statistical summary of the data elements and regression results of the current and the proposed methodologies. Exhibit 4 shows the difference in uncompensated care rates by comparing the results of the current and the proposed methodologies by hospital. Note in Exhibit 4 that the overall statewide difference is 0%.

Commission staff will publish the final results of this change in the regression variables for calculating uncompensated care when all the data for this report have been checked and validated by hospitals by the end of June 2012.

Note that as Commission staff continue to refine methodologies based on newly available data, the Commission should emphasize again to hospital staff the continued need for hospitals to ensure outpatient data quality.

Public Comments on the Draft Recommendation

During the comment period that ended May 28, 2012, staff received one comment letter. The letter is attached on page 12 of this document. In this letter, the Maryland Hospital Association is generally supportive of the idea behind the draft proposal.

Recommendation

HSCRC staff recommends that the variables "the proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits to the emergency department" and "the proportion of a hospital's total charges from outpatient services" be replaced by " the proportion of a hospital's total charges from outpatient non-Medicare emergency department charges" and "the proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits," respectively, as outpatient measures in the regression model used to establish the uncompensated care provision for Maryland acute care hospitals, effective July 1, 2012.

Exhibit 1
Policy Results from the Regression and Revenue Neutrality Adjustment for FY 2013

Hospid	Hospital Name	UCC in Rates (July 1, 2011)	Actual UCC for FY 11	Adjusted UCC for FY 11 (Includes Averted Bad Debt)	Predicted UCC	FY 09- FY 11 UCC Average	50/ 50 Blended UCC Average	Revenue Neutrality Adjustment	Policy Results without Charity Care Adjustment	Dollar Amount ($)
210001	Meritus Medical Center	6.80%	7.73%	8.94%	8.29%	8.98%	8.64%	0.9844	8.50%	23,444,650
210002	Univ. of Maryland Medical System	7.23%	7.82%	9.39%	9.92%	9.36%	9.64%	0.9844	9.49%	105,640,567
210003	Prince Georges Hospital	13.19%	14.29%	15.89%	13.67%	15.84%	14.75%	0.9844	14.52%	38,211,970
210004	Holy Cross Hospital of Silver Spring	6.82%	8.35%	9.06%	9.64%	8.36%	9.00%	0.9844	8.86%	38,779,866
210005	Frederick Memorial Hospital	5.26%	6.42%	7.30%	6.80%	6.63%	6.71%	0.9844	6.61%	21,400,256
210006	Harford Memorial Hospital	8.81%	10.59%	12.15%	10.35%	11.92%	11.13%	0.9844	10.96%	10,972,905
210007	St. Josephs Hospital	3.18%	4.53%	4.98%	4.41%	4.80%	4.61%	0.9844	4.54%	16,426,010
210008	Mercy Medical Center, Inc.	6.57%	7.67%	8.65%	7.94%	8.58%	8.26%	0.9844	8.13%	34,160,646
210009	Johns Hopkins Hospital	4.86%	3.84%	4.69%	6.40%	5.28%	5.84%	0.9844	5.75%	101,868,948
210010	Dorchester General Hospital	6.25%	6.98%	9.34%	10.44%	8.30%	9.37%	0.9844	9.23%	5,176,199
210011	St. Agnes Hospital	6.43%	6.89%	7.85%	8.25%	7.17%	7.71%	0.9844	7.59%	28,574,996
210012	Sinai Hospital	5.96%	4.82%	6.07%	8.17%	6.78%	7.48%	0.9844	7.36%	46,852,736
210013	Bon Secours Hospital	17.09%	15.35%	16.96%	15.16%	17.91%	16.54%	0.9844	16.28%	20,972,727
210015	Franklin Square Hospital	6.13%	6.24%	8.09%	10.44%	7.63%	9.04%	0.9844	8.90%	39,063,180
210016	Washington Adventist Hospital	7.81%	9.34%	10.82%	9.55%	9.90%	9.72%	0.9844	9.57%	25,401,629
210017	Garrett County Memorial Hospital	6.68%	9.40%	12.20%	10.81%	10.87%	10.84%	0.9844	10.67%	4,326,110
210018	Montgomery General Hospital	5.83%	5.84%	6.73%	6.74%	6.84%	6.79%	0.9844	6.68%	10,475,489
210019	Peninsula Regional Medical Center	5.18%	6.60%	7.77%	6.63%	7.27%	6.95%	0.9844	6.84%	27,801,973
210022	Suburban Hospital	4.37%	4.91%	5.25%	4.48%	5.15%	4.82%	0.9844	4.74%	12,010,326
210023	Anne Arundel General Hospital	3.74%	4.52%	5.19%	4.72%	4.89%	4.81%	0.9844	4.73%	21,824,663
210024	Union Memorial Hospital	4.95%	6.26%	7.43%	7.18%	6.57%	6.88%	0.9844	6.77%	27,112,686
210027	Braddock Hospital	3.58%	5.59%	7.34%	6.36%	6.17%	6.26%	0.9844	6.17%	18,803,641
210028	St. Marys Hospital	6.31%	5.38%	6.81%	9.38%	6.98%	8.18%	0.9844	8.05%	10,804,124
210029	Johns Hopkins Bayview	7.49%	6.80%	8.25%	9.85%	9.27%	9.56%	0.9844	9.41%	49,900,473
210030	Chester River Hospital Center	7.10%	9.73%	11.77%	8.85%	11.19%	10.02%	0.9844	9.86%	6,146,091
210032	Union Hospital of Cecil County	6.81%	8.63%	11.14%	11.79%	11.07%	11.43%	0.9844	11.25%	15,496,245
210033	Carroll County General Hospital	4.51%	5.25%	6.54%	6.39%	5.57%	5.98%	0.9844	5.89%	12,630,994

Final Recommendation on Changes to the Uncompensated Care Regression Model Outpatient Variables
June 6, 2012

Hospid	Hospital Name	UCC in Rates (July 1, 2011)	Actual UCC for FY 11	Adjusted UCC for FY 11 (Includes Averted Bad Debt)	Predicted UCC	FY 09- FY 11 UCC Average	50/ 50 Blended UCC Average	Revenue Neutrality Adjustment	Policy Results without Charity Care Adjustment	Dollar Amount ($)
210034	Harbor Hospital Center	7.30%	8.42%	10.84%	12.56%	9.65%	11.11%	0.9844	10.93%	21,944,912
210035	Civista Medical Center	6.24%	7.71%	9.05%	10.72%	7.63%	9.18%	0.9844	9.03%	10,435,658
210037	Memorial Hospital at Easton	4.52%	5.56%	7.21%	7.38%	6.05%	6.71%	0.9844	6.61%	11,444,207
210038	Maryland General Hospital	11.04%	11.84%	13.92%	14.72%	12.96%	13.84%	0.9844	13.62%	24,953,331
210039	Calvert Memorial Hospital	5.60%	5.76%	7.09%	8.85%	6.77%	7.81%	0.9844	7.69%	9,933,152
210040	Northwest Hospital Center, Inc.	6.63%	7.44%	8.81%	8.66%	8.87%	8.76%	0.9844	8.63%	19,638,840
210043	North Arundel General Hospital	6.67%	8.87%	10.00%	8.61%	8.96%	8.79%	0.9844	8.65%	30,596,812
210044	Greater Baltimore Medical Center	3.28%	3.08%	3.59%	4.86%	3.37%	4.11%	0.9844	4.05%	17,283,575
210045	McCready Foundation, Inc.	8.22%	14.17%	17.48%	12.27%	14.26%	13.27%	0.9844	13.06%	2,381,376
210048	Howard County General Hospital	5.65%	5.84%	6.53%	8.67%	6.25%	7.46%	0.9844	7.35%	18,767,138
210049	Upper Chesapeake Medical Center	5.62%	6.73%	7.59%	7.59%	7.39%	7.49%	0.9844	7.37%	16,685,167
210051	Doctors Community Hospital	7.70%	7.77%	9.22%	8.85%	9.46%	9.16%	0.9844	9.01%	19,206,095
210054	Southern Maryland Hospital	7.00%	8.47%	9.59%	9.56%	9.05%	9.31%	0.9844	9.16%	20,452,801
210055	Laurel Regional Hospital	10.01%	12.50%	13.93%	12.60%	13.03%	12.81%	0.9844	12.61%	13,001,013
210056	Good Samaritan Hospital	4.90%	5.67%	6.85%	7.65%	6.36%	7.01%	0.9844	6.90%	20,977,595
210057	Shady Grove Adventist Hospital	6.27%	6.32%	7.35%	8.59%	7.15%	7.87%	0.9844	7.75%	25,984,100
*210058	James Lawrence Kernan Hospital	6.56%	7.05%	7.79%	7.36%	7.98%	7.67%	1.0000	7.67%	7,945,067
210060	Fort Washington Medical Center	10.56%	13.11%	14.36%	15.75%	14.42%	15.09%	0.9844	14.85%	6,645,124
210061	Atlantic General Hospital	5.31%	6.76%	8.15%	7.65%	7.51%	7.58%	0.9844	7.46%	6,578,101
	STATE-WIDE	6.13%	6.63%	7.82%	8.25%	7.64%	7.95%	0.9844	7.82%	1,079,134,166

** Kernan Hospital was excluded in the Regression Analysis, Revenue Neutrality and Charity Care Adjustment Calculations*

Exhibit 2
Summary of the Preliminary Results of the Proposed Recommendation

Hospid	Hospital Name	FY 2013 Policy Result w/o Charity Adjustment	FY 2013 Policy Result with Charity Adjustment
210001	Meritus Medical Center	8.50%	8.57%
210002	Univ. of Maryland Medical System	9.49%	9.59%
210003	Prince Georges Hospital	14.52%	15.07%
210004	Holy Cross Hospital of Silver Spring	8.86%	8.93%
210005	Frederick Memorial Hospital	6.61%	6.56%
210006	Harford Memorial Hospital	10.96%	10.36%
210007	St. Josephs Hospital	4.54%	4.40%
210008	Mercy Medical Center, Inc.	8.13%	8.08%
210009	Johns Hopkins Hospital	5.75%	5.77%
210010	Dorchester General Hospital	9.23%	9.38%
210011	St. Agnes Hospital	7.59%	7.80%
210012	Sinai Hospital	7.36%	7.31%
210013	Bon Secours Hospital	16.28%	16.78%
210015	Franklin Square Hospital	8.90%	8.88%
210016	Washington Adventist Hospital	9.57%	9.58%
210017	Garrett County Memorial Hospital	10.67%	11.19%
210018	Montgomery General Hospital	6.68%	6.96%
210019	Peninsula Regional Medical Center	6.84%	6.80%
210022	Suburban Hospital	4.74%	4.65%
210023	Anne Arundel General Hospital	4.73%	4.61%
210024	Union Memorial Hospital	6.77%	6.84%
210027	Braddock Hospital	6.17%	6.51%
210028	St. Marys Hospital	8.05%	8.12%
210029	Johns Hopkins Bayview Med. Center	9.41%	9.65%
210030	Chester River Hospital Center	9.86%	10.45%
210032	Union Hospital of Cecil County	11.25%	10.89%
210033	Carroll County General Hospital	5.89%	5.74%
210034	Harbor Hospital Center	10.93%	10.94%
210035	Civista Medical Center	9.03%	8.71%
210037	Memorial Hospital at Easton	6.61%	6.64%
210038	Maryland General Hospital	13.62%	13.54%
210039	Calvert Memorial Hospital	7.69%	7.86%
210040	Northwest Hospital Center, Inc.	8.63%	8.34%
210043	North Arundel General Hospital	8.65%	8.48%
210044	Greater Baltimore Medical Center	4.05%	4.02%
210045	McCready Foundation, Inc.	13.06%	12.88%

210048	Howard County General Hospital	7.35%	7.23%
210049	Upper Chesapeake Medical Center	7.37%	7.04%
210051	Doctors Community Hospital	9.01%	8.58%
210054	Southern Maryland Hospital	9.16%	8.74%
210055	Laurel Regional Hospital	12.61%	12.84%
210056	Good Samaritan Hospital	6.90%	6.86%
210057	Shady Grove Adventist Hospital	7.75%	7.76%
*210058	James Lawrence Kernan Hospital	7.67%	7.67%
210060	Fort Washington Medical Center	14.85%	14.04%
210061	Atlantic General Hospital	7.46%	7.21%
	STATE-WIDE	7.82%	7.82%

** Kernan Hospital was excluded in the Regression Analysis, Revenue Neutrality and Charity Care Adjustment Calculations*

Exhibit 3
Statistical Summary of the Data Elements and Regression Results

Proposed Methodology				
R-Square	0.7709			
Adjusted R-Square	0.7602			
Variables:	**Parameter Estimate**	**Standard Error**	**t Value**	**P-Value (Pr > |t|)**
The proportion of a hospital's total charges from inpatient non-Medicare admissions through the emergency room	0.07049	0.03436	2.05	0.0423
The proportion of a hospital's total charges from inpatient Medicaid, self-pay and charity	0.15278	0.03547	4.31	<.0001
The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits	0.39646	0.06088	6.51	<.0001
The proportion of a hospital's total charges from Non-Medicare outpatient emergency department charges	0.24729	0.04234	5.84	<.0001

Current Methodology				
R-Square	0.7837			
Adjusted R-Square	0.7736			
Variables:	**Parameter Estimate**	**Standard Error**	**t Value**	**P-Value (Pr > |t|)**
The proportion of a hospital's total charges from inpatient non-Medicare admissions through the emergency room	0.11522	0.03127	3.68	0.0003
The proportion of a hospital's total charges from inpatient Medicaid, self-pay and charity	0.15665	0.03306	4.74	<.0001
The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits to the emergency room	0.78528	0.08957	8.77	<.0001
The proportion of a hospital's total charges from outpatient services	0.07588	0.02966	2.56	0.0117

Exhibit 4
Current Policy vs. the Proposed Policy - Difference in Hospital-Specific UCC Rates

Hospid	Hospital Name	FY 2013 Policy Result with Charity Adjustment (Current Policy)	FY 2013 Policy Result with Charity Adjustment (Proposed Policy)	Difference
210001	Meritus Medical Center	8.72%	8.57%	-0.15%
210002	Univ. of Maryland Medical System	9.14%	9.59%	0.45%
210003	Prince Georges Hospital	15.51%	15.07%	-0.44%
210004	Holy Cross Hospital of Silver Spring	8.54%	8.93%	0.39%
210005	Frederick Memorial Hospital	6.76%	6.56%	-0.20%
210006	Harford Memorial Hospital	10.45%	10.36%	-0.09%
210007	St. Josephs Hospital	4.57%	4.40%	-0.17%
210008	Mercy Medical Center, Inc.	8.51%	8.08%	-0.44%
210009	Johns Hopkins Hospital	5.91%	5.77%	-0.14%
210010	Dorchester General Hospital	9.75%	9.38%	-0.37%
210011	St. Agnes Hospital	7.94%	7.80%	-0.14%
210012	Sinai Hospital	7.29%	7.31%	0.02%
210013	Bon Secours Hospital	16.99%	16.78%	-0.21%
210015	Franklin Square Hospital	8.86%	8.88%	0.01%
210016	Washington Adventist Hospital	9.80%	9.58%	-0.23%
210017	Garrett County Memorial Hospital	10.82%	11.19%	0.37%
210018	Montgomery General Hospital	7.11%	6.96%	-0.15%
210019	Peninsula Regional Medical Center	6.86%	6.80%	-0.06%
210022	Suburban Hospital	4.68%	4.65%	-0.03%
210023	Anne Arundel General Hospital	4.85%	4.61%	-0.23%
210024	Union Memorial Hospital	6.91%	6.84%	-0.07%
210027	Braddock Hospital	6.46%	6.51%	0.06%
210028	St. Marys Hospital	7.71%	8.12%	0.41%
210029	Johns Hopkins Bayview	8.96%	9.65%	0.69%
210030	Chester River Hospital Center	10.52%	10.45%	-0.08%
210032	Union Hospital of Cecil County	10.87%	10.89%	0.02%
210033	Carroll County General Hospital	5.77%	5.74%	-0.03%
210034	Harbor Hospital Center	11.17%	10.94%	-0.23%
210035	Civista Medical Center	8.70%	8.71%	0.00%
210037	Memorial Hospital at Easton	6.78%	6.64%	-0.14%
210038	Maryland General Hospital	13.39%	13.54%	0.16%
210039	Calvert Memorial Hospital	8.00%	7.86%	-0.14%
210040	Northwest Hospital Center, Inc.	8.53%	8.34%	-0.20%
210043	North Arundel General Hospital	8.68%	8.48%	-0.20%
210044	Greater Baltimore Medical Center	4.19%	4.02%	-0.17%
210045	McCready Foundation, Inc.	12.91%	12.88%	-0.03%

Hospid	Hospital Name	FY 2013 Policy Result with Charity Adjustment (Current Policy)	FY 2013 Policy Result with Charity Adjustment (Proposed Policy)	Difference
210048	Howard County General Hospital	6.85%	7.23%	0.39%
210049	Upper Chesapeake Medical Center	6.89%	7.04%	0.14%
210051	Doctors Community Hospital	8.89%	8.58%	-0.32%
210054	Southern Maryland Hospital	8.64%	8.74%	0.10%
210055	Laurel Regional Hospital	12.67%	12.84%	0.17%
210056	Good Samaritan Hospital	7.01%	6.86%	-0.16%
210057	Shady Grove Adventist Hospital	7.31%	7.76%	0.45%
*210058	James Lawrence Kernan Hospital	5.82%	7.67%	1.85%
210060	Fort Washington Medical Center	14.17%	14.04%	-0.13%
210061	Atlantic General Hospital	7.48%	7.21%	-0.28%
	STATE-WIDE	7.82%	7.82%	0.00%

** Kernan Hospital was excluded in the Regression Analysis, Revenue Neutrality and Charity Care Adjustment Calculations*

Maryland
Hospital Association

MHA
6820 Deerpath Road
Elkridge, Maryland 21075-6234
Tel: 410-379-6200
Fax: 410-379-8239

May 21, 2012

Andy Udom
Associate Director, Research and Methodology
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Mr. Udom:

On behalf of our 66 member organizations, the Maryland Hospital Association supports the Health Services Cost Review Commission staff's May 2 *Draft Recommendation on Changes to the Uncompensated Care Regression Model Outpatient Variables.* Because outpatient data reporting is now more specific and complete, it makes good sense to refine the outpatient variables used to predict hospitals' uncompensated care as part of the uncompensated care policy. Refining the outpatient variables is statistically sound and reflects the trend toward providing a greater proportion of health care services in the outpatient setting.

We appreciate the opportunity to contribute to the development of this policy and to comment on the recommendation.

Sincerely,

Traci La Valle

Traci La Valle
Vice President, Financial Policy & Advocacy

Nurse Support Program II: FY 2013 Competitive Institutional Grants

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
410-764-2605

June 6, 2012

This final recommendation was approved at the June 6, 2012 Public Commission Meeting.

Background

This recommendation presents the Evaluation Committee and HSCRC staff recommendations for the FY 2013 Nurse Support Program II (NSP II) Competitive Institutional Grants.

In 2005, the Commission approved funding of 0.1 percent of regulated patient revenue annually for ten years for use in expanding the pool of bedside nurses in Maryland by increasing the number of nurse graduates. NSP II aims to increase the number of bedside nurses by expanding the capacity of Maryland nursing schools and, thereby, increase the number of nurse graduates. NSP II consists of two distinct but complementary programs to address the multi-faceted issues surrounding the nursing faculty shortage. These are the Competitive Institutional Grants and the Statewide Initiatives.[1]

The Competitive Institutional Grants are designed to increase the structural capacity of Maryland Schools of Nursing through shared resources, innovative educational designs, and streamlining the process to produce additional nurse faculty.

The types of initiatives that qualify for Competitive Intuitional Grants are:

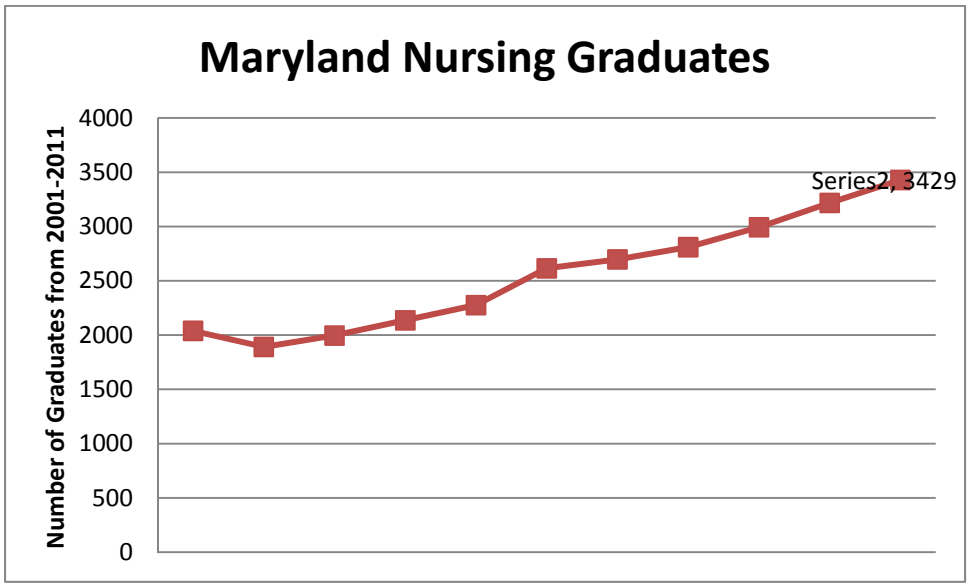
1. Initiatives to expand Maryland's nursing capacity through shared resources, to combine and integrate resources to allow for immediate expansion of nursing enrollments and graduates
2. Initiatives to increase Maryland's nursing faculty by streamlining the process for the attainment of Master's and Doctoral Degrees in Nursing to increase nursing faculty.
3. Initiatives to improve nursing student retention by providing tutorial support to decrease attrition, increase graduation rates, and increase National Council Licensure Examination (NCLEX) pass rates
4. Initiatives to expand the pipeline for nursing faculty by streamlining and facilitating the transition between institutions for nurses with either an Associate Degree in Nursing or a Bachelor of Science in Nursing to pursue a Master's Degree in Nursing, thereby increasing the pool of qualified nursing faculty
5. Initiatives to increase capacity statewide by providing support for innovative programs that have a statewide impact on the capacity to train nurses or nursing faculty

Impact of NSP II Competitive Institutional Grants

Data from the Maryland Higher Education Commission (MHEC) and the Maryland Board of Nursing demonstrate success in increasing the number of nursing graduates in Maryland.[2]

- In FY 2011, 3,429 nursing graduates completed programs designed for entry to practice with 2,519 passing NCLEX for licensure. This is an increase from the 2,615 new nursing graduates in FY 2006 with 2,039 passing NCLEX for licensure. Overall, the trend for five years has been a 19 percent increase in new graduate nurses.

[1] Statewide Initiatives include the Hal and Jo Cohen Graduate Nursing Scholarship, New Nurse Faculty Grants, and Dissertation Support Awards.
[2] The HSCRC contracts with the Maryland Higher Education Commission (MHEC) to administer the NSP II program.



- The increase in new faculty prepared nurses to sustain nursing educational capacity in FY 2011 reflects a total of 505 new degrees awarded at the graduate level. Since the 303 new Master's and Doctoral Degrees awarded in FY 2006, there has been a significant increase. The outcomes seen here with the joint partnership of MHEC and HSCRC are strongly associated with decreased vacancy rates reported by the Maryland Hospital Association and increasing stabilization of faculty openings in nursing programs reported by Maryland Deans and Directors of Nursing.

From FY 2006 - 2012, outcomes reported through the Competitive Institutional Grant projects indicate over 1,000 new Registered Nurses graduated with an additional 300 nurses returning to school to complete the BSN, 250 completing graduate education, and 100 completing a post-graduate level certificate in education. Nursing programs have hired over 35 new full-time nursing faculty through NSP II in the past academic year with nearly half of the hired faculty from under-represented minorities in nursing. NSP II is directly expanding gender, racial, and ethnic diversity in nurse faculty.

The Nurse Support Program II is frequently referenced in nursing and health care industry journals. Several teams from Maryland will make presentations at the Sigma Theta Tau International 23rd International Nursing Research Congress in July, 2012 with reference to the NSP II program model for nursing education.

Competitive Institutional Grant Selection Process

Request for Applications for Competitive Institutional Grants are distributed annually by MHEC and HSCRC to all schools of nursing, and posted on MHEC's website with an invitation to meet with program staff at Technical Assistance Meetings. The NSP II's focus is on the education of nurses; therefore, the concentration is on the nursing educational system including university, college and community college schools of nursing, as well as hospital and school consortia. The application is structured with detailed instructions in each of seven sections for a total of 15 pages, including a proposed budget utilizing a standardized format.

The Competitive Institutional Grant selection processes require an Evaluation Committee to review, deliberate, and recommend programs for final approval by the HSCRC. The Evaluation

Committee reviews each application based on the criteria set forth in the RFA with specific scoring for each section. Consideration is given to the geographic distribution across the State with priority attached to attracting and retaining minorities in nursing and nursing faculty careers.

NSP II Competitive Institutional Grants from FY 2007 – FY 2012

Between FY 2007 and FY 2012, nursing programs have submitted 95 NSP II Competitive Intuitional Grant applications, and the HSCRC has approved and funded 67 applications. Over that period of time, the program has provided $51 million in funding for projects that have:

- Accelerated the number of Associate Degree graduates with weekend, evening, and 15 month to completion options
- Included non-traditional entry into the nursing profession by degree-holding career changers and underrepresented populations
- Provided graduate nurses a specialty post- graduate Certificate in Nursing Education
- Developed partnerships among community colleges and universities with Maryland Faculty Academy for Clinical Simulation (M-FAST) and Eastern Shore Faculty Academy (ES-FAM)
- Developed Doctor of Nursing Practice (DNP) programs utilizing a variety of strategies, distance and web-based technologies to increase the capacity for doctoral students in the State
- Created new simulation scenarios for statewide use, conserving resources and harnessing intellectual capital for shared links on multiple schools of nursing with reference to support of the NSP II
- Improved student retention rates and success in nursing programs with higher NCLEX pass rates on initial licensure examinations
- Supported new nursing programs, including several at Maryland's Historically Black Colleges and Universities (HBCU), with the goal of increasing diversity of the nursing workforce and support for underrepresented minorities in faculty development

On an ongoing basis, MHEC staff conducts site monitoring visits to NSP II grant awardees to assist with and ensure program success in accordance with the approved project. In general, MHEC has found: compliance to program and budgetary agreements; reporting within the guidelines; measurable impact of programs and active mentoring of new faculty. A well-recognized State action coalition composed of nursing and industry leaders volunteering on subcommittees started in the fall of 2011 for implementation of the Institute of Medicine recommendations in The Future of Nursing Report (2010). Deans and Directors of Nursing Programs have provided strong leadership and collaborative oversight with clear investment in nursing education and the mission of NSP II.

NSP II Competitive Institutional Grants for FY 2013

For FY 2013, MHEC received eighteen proposals. The seven-member Evaluation Committee comprised of hospital nursing administrators, community college and university nursing

educators, licensure and policy leaders along with MHEC and HSCRC staff, reviewed all of the proposals and agreed to recommend funding for twelve of the eighteen requests for two to three year programs totaling $4,395,261. See Table 1 for a listing of the recommended grant awardees for FY 2013.

The most highly recommended application was representative of diversity and faculty mentoring with an innovative partnership between the lead private institutions of higher learning, Sojourner- Douglass College and Morgan State University, an established HBCU. The second most highly recommended was a new doctorate program (DNP) specializing in rural health at the only public university on the Eastern Shore, Salisbury University, utilizing distance educational strategies for ease of access to advanced education. Several applications built on former program success increasing the representation of men to 25 percent in accelerated programs near military bases, doubling the number of seats available to doctoral students, advancing simulation and extending clinical faculty education to new hospital partners. Twenty-three Maryland educational institutions and hospital partners will be involved in the twelve proposed grants programs with two to three year time frames in FY 2013. With this cycle of grants, all 26 Maryland Schools of Nursing have participated in at least one of the NSP II grant cycles, indicative of inclusivity and diversity across the State of Maryland.

Attachment 1: Recommendations for Competitive Institutional Grant Awards for FY 2013

Attachment I

Nurse Support Program II FY 2013 Competitive Institutional Grant Proposal Recommendations

WORKSHEET 5.24.12

INSTITUTION	TITLE	PROJECT DIRECTOR	AFFILIATES	AMOUNT	DURATION	Year 1	Year 2	Year 3	Year 4	TOTAL REQUEST	REVISIONS	2013	2014	2015	TOTAL AWARD
Highly Recommended															
Sojourner Douglass College School of Nursing	Faculty Mentoring and Development Increases Capacity and Student Success	Dr. Arlene Johnson	Morgan State University SON	$165,233	2 years	$82,927	$82,296			$165,233		$82,927	$82,296		$165,223
Salisbury University - Department of Nursing	Expediting Doctoral Education on the ES: Initiatives to Expand Maryland's Capacity for Preparing Nursing Faculty	Dr. Lisa Seldomridge	none	$1,079,644	3 years	$341,172	$384,719	$353,753		$1,079,644		$341,172	$384,719	$353,753	$1,079,644
Montgomery College	NSP II Model for Dual Enrollment (MDE)	Barbara Nubile	University of Maryland at Shady Grove	$161,313	1.5 years	$108,693	$52,620			$161,313		$108,693	$52,620		$161,313
Recommended with Revisions	**Tier 1**														
Johns Hopkins University School of Nursing	Post Docs for Maryland DNPs: Center Development to Impact Education & Practice	Dr. Mary Terhaar	Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Howard County General & Greater Baltimore Medical Center	$880,408	3 years	$288,871	$293,438	$298,098		$880,408		$288,871	$293,438		$582,309
Wor-Wic Community College	Nursing Advising, Retention and Success Program	Dr. Denise Marshall	none	$210,887	3 years	$68,683	$70,280	$71,925		$210,887		$62,640	$62,640	$62,640	$187,920
University of Maryland School of Nursing	The Doctor of Nursing Practice: A Project to Increase Maryland's Nursing Faculty	Dr. Patricia Morton	none	$606,203	2 years	$296,998	$309,205			$606,203		$231,703	$231,703		$463,406
Recommended with Revisions	**Tier 2**														
Harford Community College	The ASNAP Project-Accelerated Studies in Nursing: Analyses for Promulgation	Laura Preston	Upper Chesapeake Health	$634,432	3 years	$211,478	$211,477	$211,477		$634,432		$111,478	$111,477	$211,477	$434,432
Cecil Community College	Retention Program for Cecil College Nursing Program	Christy Dryer	None	$173,071	3 years	$34,417	$138,566	$ 26,944		$173,071		$25,465	$73,803	$73,803	$173,071
Frederick Community College	Simplifying Retention	Vanessa Lovato Maura David	none	$128,484	3 years	$79,728	$24,378	$24,378		$128,484		$75,138	$24,378		$99,516
Coppin State University	Operation Success Initiative Program	Dr. Marcella Copes	none	$921,478	3 years	$329,914	318,349	$311,437		$921,478		$149,914	$178,349	$211,437	$539,700
Recommended with Revisions if Funding allows	**Tier 3**														
Johns Hopkins University School of Nursing	Guiding Inittiative for Doctoral Education Program (GuIDE)	Dr. Laura Taylor	JHH, JHBMC, JHCC, Suburban Hospital, Frederick Memorial	$631,360	3 years	$210,687	$208,631	$212,042		$631,360		$67,448	$65,265	$66,352	$199,065
University of Maryland School of Nursing	Master's Preparation of Staff Nurses to Expand Clinical Instruction Capacity	Dr. Mary Etta Mills	GBMC, MGH, St Joseph Medical Center	$963,569	4 years	$142,727	$166,935	$321,812	$ 332,095	$963,569		$142,727	$166,935		$309,662
												$1,688,176	1,727,623	$979,462	$4,395,261
Proposals Non-Funded	**for FY 2013**														
Frostburg University	Increasing Nursing Faculty in Maryland- Tracking your Pathway to MSN	Heather Gable	none	$338,564	3 years	$97,735	$112,922	$127,906		$338,564					
Towson University	Associate to Bachelor's Degree Program	Dr. Sheila Green & Dr. Kimberly Christopher	Community College of Baltimore County and Hagerstown CC	$1,246,133	3 years	$426,415	$404,135	$415,583		$1,246,133					
Hagerstown Community College	IT in the ER and Beyond: Technology Enhanced Nursing Education	Karen Hammond & Dr. Elaine Ashby	none	$649,999	3 years	$242,461	$254,937	$152,601		$649,999					
Coppin State University	Increasing Maryland's Nursing Faculty through Expanded Nursing Education Course Offering for MSN and DNP students	Dr. Joan Tilghman	St. Agnes Hospital	$688,811	3 years	$277,798	$205,090	$205,923		$688,811					
Montgomery College	NSP II Exam Development (ED)	Barbara Nubile	Up to 14 Schools of Nursing	$478,222	2 years	$317,847	$160,375			$478,222					
Sojourner Douglass College School of Nursing	Implementing SDT in the Workplace: A Collaborative Model for Developing Staff Nurses in Mentors/ Preceptors	Dr. Maija Anderson & Dr. Gina Brown	Dimensions Healthcare & Prince George's Hospital	$222,264	2 years	$116,586	$105,678			$222,264					

Total requests 18 applications 13 SON $10,180,075

Recommendations

1. Based on selection by the Evaluation Committee, HSCRC staff recommends the Commission approve the twelve Competitive Institutional Grants listed in Table 1 for award in the funding amounts stated.
2. HSCRC staff recommends the Commission to direct MHEC staff to evaluate the current Competitive Institutional Grant program and recommend changes, as needed, to ensure maximum effectiveness in the final years of NSP II grant awards.
3. HSCRC staff recommends waiving the 60-day comment so that this recommendation is considered for final approval during this June Commission meeting.

Draft Report on Nurse Support Program I (NSP I) Activities for FY 2007 - FY 2012 and Recommendations for Refunding

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
410-764-2605

June 6, 2012

This recommendation is a draft proposal. No Commission action is required at this time. Public comments should be sent to Claudine Williams at the above address or by e-mail at cwilliams@hscrc.state.md.us. For full consideration, comments must be received by June 28, 2012.

Purpose

This recommendation summarizes the activities of the Nurse Support Program I during the last 5 year cycle (FY 2007-FY 2012), and recommends renewal of the program for another 5 year cycle with modifications.

Background

In 1986, the HSCRC initiated nurse education support through the collaborative efforts of hospitals, payers, and nursing representatives in response to a growing nursing shortage in Maryland. Originally, the Nurse Education Support Program (NESP) focused on supporting college and hospital-based training of Registered Nurses (RNs) and Licensed Practical Nurses (LPNs). Over the years, the NESP expanded to encourage new and innovative approaches to address the challenges and demands facing the nursing profession and allied professions. HSCRC allocated approximately $7 million in hospital rates to thirty-seven hospitals that participated in the NESP from 1986 through 1995 when the program concluded.

As the economic situation in the US improved during the late 1990s-early 2000, another nursing shortage emerged. In 200l, the U.S. General Accounting Office conducted a study regarding the state of the nursing workforce in response to a congressional inquiry.[1] Results indicated that although national data were not adequate to describe the nature and extent of the potential nurse shortage, there was compelling evidence (declines in the RN unemployment rate and the RNs per capita) that suggests that the nursing shortage was a real phenomenon and that it would continue to grow. According to data from the National Sample Survey of Registered Nurses, there was a 2 percent decline nationally in the number of employed nurses per 100,000 people between 1996 and 2000. The study also listed multiple obstacles to increasing the supply of nurses including, an aging workforce, declines in younger nurses entering the field, a general dissatisfaction with the nursing environment (particularly staffing levels), concerns with quality of patient care, and lack of administrative support.

Although there was a slight (1.7 percent) increase in the number of employed RNs for the same time period in Maryland, the nursing workforce was experiencing similar dissatisfaction, according to a survey conducted by the Maryland Commission on the Crisis in Nursing in 2001.[2] In an effort to sustain and improve the number of bedside nurses in Maryland, the HSCRC initiated a new five–year, hospital-based, non-competitive grant program in 2000. The primary focus of Nurse Support Program I (NSP I) was increasing the number of bedside nurses in Maryland through retention and recruitment initiatives. Hospitals submitted proposals to the HSCRC for three- to five-year projects that ranged from nursing educational scholarships for their employees to high school outreach. A multi-stakeholder Evaluation Committee, comprised of nurse experts, reviewed the proposals and made recommendations to the Commission for funding. Funding was distributed through an increase in each hospital's rates equal to 0.1 percent of their regulated gross patient revenue from the prior year. Almost all Maryland acute care hospitals participated in NSP I from 2001-2006, receiving almost $36 million in rates.

[1] United States General Accounting Office, Nursing Workforce: Emerging Nurse Shortages Due to Multiple Factors (GAO-01-944, July 2001)
[2] Workplace Survey 2001. Maryland Commission on the Crisis in Nursing. Maryland Board of Nursing, Workplace Issues Subcommittee.

2007 Evaluation and Recommendation to the Commission

In 2005, HSCRC staff conducted an evaluation of the NSP I program, in part, because of difficulties in demonstrating program outcomes and accountability, unclear guidelines for eligible program activities, and a need to define the scope of the NSP I considering the initiation of the NSP II program in FY 2006. The Commission established the following NSP I evaluation goals:

- Clarify the categories of programs eligible for funding
- Fund projects deemed most valuable by nursing experts
- Simplify the application and reporting process, and
- Increase accountability through standardized program outcome and financial reporting

With the assistance of hospital industry, NSP I coordinators, nurse executives and educators, the Board of Nursing, and HSCRC leadership, HSCRC re-evaluated the NSP I program. HSCRC staff also contracted with a nurse researcher with nationally recognized expertise on the nursing shortage to provide consultation in program review and evaluation, and assistance with development of a standardized, objective reporting format. Upon completion of the evaluation, HSCRC staff recommended to the Commission the following modifications to the NSP I program:

1. Redefine categories of initiatives eligible for funding and establish categories that are ineligible for funding
2. Revise the Request for Applications process for grant funding to a simplified application process
3. Revise the review and evaluation process for initiative approvals and renewals
4. Ongoing review of the funding mechanism; and
5. Standardize quantitative annual reports to include uniform financial and annual data reporting requirements

The Commission approved program modifications and renewed funding for another five-year cycle from FY 2008 to FY 2012.

Implementation of Modified NSP I Program

Application Process

In the spring of 2007, hospitals submitted proposals in response to an HSCRC-issued Request for Applications (RFAs) that incorporated areas recommended by nurse experts as being most valuable in improving nurse retention and the supply of bedside nurses. HSCRC staff encouraged hospitals to propose programs that included one or more of the following broad categories:

- **Educational Attainment**: This category includes all initiatives involving improved educational qualifications for nurses (RNs and LPNs) as well as initiatives to produce more nurses. Examples include: tuition, stipends, or release time for pursuit of additional education or qualification; software and hardware specifically dedicated for use in nursing education would be considered on an individual basis.

- **Nurse Retention and Recruitment:** This category applies to all initiatives involving retention of nurses. Examples include: mentoring, internships, residencies, and other support for new graduates and new hires, as well as, all initiatives involving recruitment including nurse shadowing programs, externships, and summer employment for prospective nursing students.
- **Improved Nurse Practice Environment:** This category applies to all initiatives to improve nurse practice environment including working on or achieving Magnet Status, joint governance, and other initiatives to improve nurse practice environment.

  For those healthcare organizations that did not plan to work toward achieving Magnet Status, projects related to the components of Magnet Status, or "Forces of Magnetism," such as implementation of professional standards of nursing practice, a nursing quality indicator program, or applied nursing research. Other examples include: programs to develop new approaches to staffing, scheduling, and allocation of patient care resources.
- **Other Creative Initiatives Proposals** to increase the number of bedside nurses will be considered provided that the goals and objectives are clearly defined, evaluation metrics are identified, and budget requests fall within the defined NSP I parameters. These initiatives might include projects that require outside expertise that could be shared, such as the Project LINC and the Nurse Managers Leadership Institute, previously funded in part by NSP I.

An independent NSP I Evaluation Committee, comprised of representatives from HSCRC staff, hospital nursing leadership, payers, nursing recruiters, the Maryland Hospital Association, the Maryland Higher Education Commission, and human resources professionals reviewed the applications that met the minimum requirements outlined in the application form. The Evaluation Committee recommended 43 hospitals for funding for FY 2008, and the Commission approved the recommendation.

Revisions to the Annual Reports

HSCRC required hospitals to submit a standardized annual report and budget form at the end of each fiscal year. HSCRC staff expanded the annual report to include metrics that addressed the varied programs the hospitals proposed. HSCRC staff also developed a standardized budget form to assist in tracking how hospitals expended NSP I funds. HSCRC staff required hospitals to submit a proposed budget form at the beginning of the fiscal year. At the end of the fiscal year, hospitals reported their actual expenditures. HSCRC staff reduced the following year's budget request by the amount of the unspent funds in the prior year.

NSP I Achievements

The primary goal of the NSP I Program is to increase the number of bedside nurses in Maryland through retention and recruitment. Over the last 5 years, Maryland hospitals have met and exceeded this goal. The funding provided by NSP I has enabled hospitals to promote, nursing through enhanced educational opportunities, leadership development, research and joint governance. Hospitals indicate that these efforts have translated into higher satisfaction among Maryland nurses and better outcomes for patients.

Increased the Number of Bedside Nurses

In recent years, there has been a resurgence of nurses in the workforce. According to the HSCRC Wage and Salary Survey, Maryland hospitals increased the number of nurses by 15 percent between 2007 and 2011 (Chart 1). Eleven hospitals increased their nursing staff by more than 25 percent. There are several factors that may contribute to the increase in nursing workforce, including the state of the economy; nurses who would have otherwise retired are staying in their jobs or increasing their hours.[3] However, studies are predicting that this trend is temporary. The increasing demand for nurses to care for an aging nation, coupled with reduction in the workforce as nurses retire, will create an "unprecedented shortage of RN's in the United States."[4]

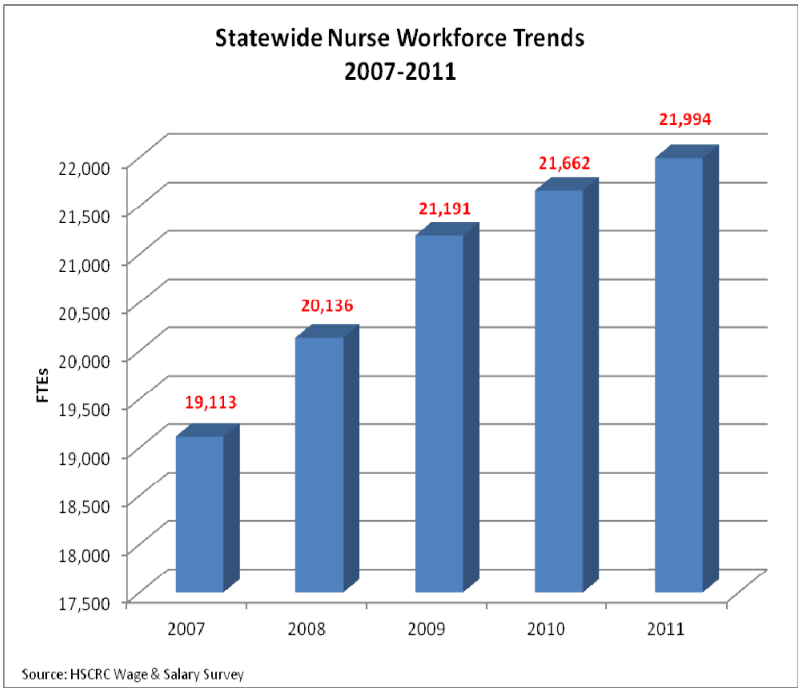


Chart 1

[3] P. I. Buerhaus. Current and Future State of the US Nursing Workforce. *Journal of the American Medical Association*. 300:20 (2008).
[4] D.I. Auerbachm, P.I. Buerhaus & D.O. Staiger. Registered Nurse Supply Grows Faster Than Projected Amid Surge In New Entrants: Ages 23 -26. *Health Affairs*, 30, no.12 (2011):2286-2292; B.L.Cleary, A.B. McBride, M.L.McClure, & S.C. Reinhard. Expanding The Capacity Of Nursing . *Health Affairs*, 28, no.4 (2009):w634-w645

Hospitals attribute another reason for the increase in their nurse workforce to initiatives funded by the NSP I program. NSP I funding has enabled hospitals to develop programs aimed toward attracting and retaining new nursing graduates through rigorous residency and orientation programs, promoting nursing education for clinical and non-clinical staff, and providing extern and intern opportunities for nursing students who are subsequently hired as staff. For example, Johns Hopkins Hospital's Social and Professional Reality Integration for Nurse Graduates (SPRING) program focused on the retention of new graduate nurses in adult inpatient and critical care departments through a year-long internship. Through this program, Hopkins has been able to maintain an average retention rate of 88 percent among new graduates over the last 5 years. Franklin Square Hospital Center, through established partnerships with the weekend nursing program at Community College of Baltimore County (CCBC), increased the number of bedside RNs by offering tuition assistance to 30 non-clinical staff. With NSP I funding, Upper Chesapeake Medical Center (UCMC) sponsored an externship program where 90 percent of the students in the program have accepted RN positions at UCMC or at Harford Memorial Hospital. The externship program at Union Memorial Hospital (UMH) has produced 78 bedside nurses since FY2007; 59 of these nurses are currently employed at UMH.

Reduced Dependency on Agency Nurses

According to the HSCRC Wage and Salary survey, Maryland hospitals decreased their dependence on agency nurses by 68 percent, saving more than $98 million in agency costs between FY 2007 and FY 2011 (Chart 2). NSP I coordinators cite improved retention of existing nurses as the reason for the decreased usage of agency nurses.

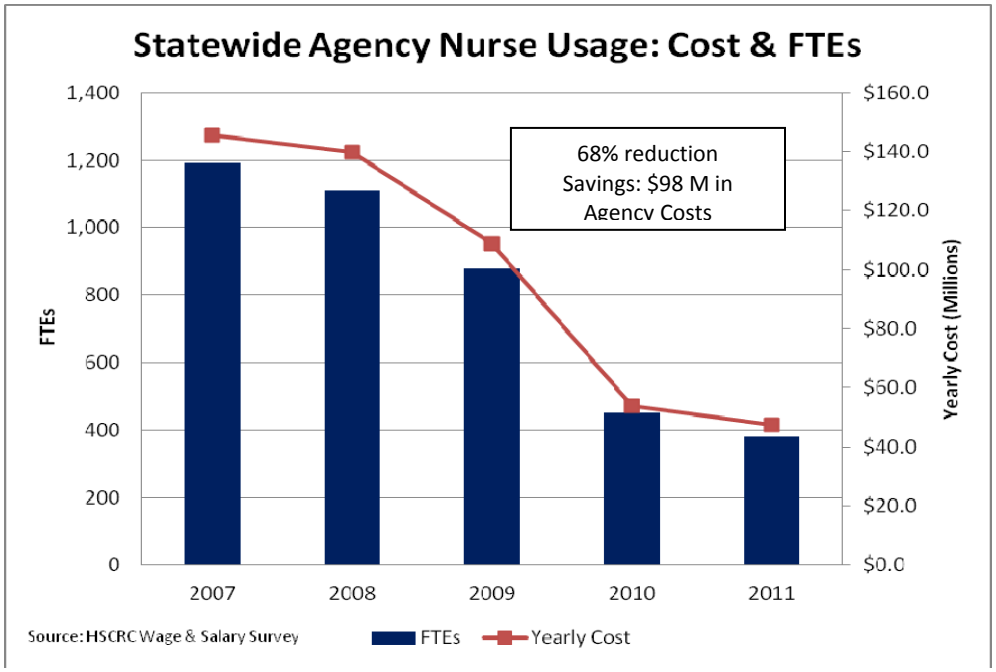


Chart 2

Increased the Number of Certified and Advanced Degree Nurses

A number of studies have shown a link between higher nursing education and better patient outcomes. One study showed compelling evidence that a 10 percent increase in the number of BSN degree nurses decreased the risk of patient death and failure to rescue by 5 percent.[5] In an effort to improve the level of education of their nursing staff, Maryland hospitals spent approximately $8.5 million on scholarships and tuition reimbursement for nursing education through the NSP I program between 2008 and 2011. Hospitals provide a majority of these funds (64 percent) for scholarships and tuition reimbursement for their nursing staff. Although, the number of hospitals reporting tuition assistance between FY 2008 and FY 2011 dropped from 25 hospitals to 19, investment in their staff's education more than doubled between FY 2008 and FY 2011, from $790,000 to $1.6 million respectively, peaking in FY2010 at $2.2 million. Maryland hospitals also invested close to $3 million in local nursing students through scholarships. In return, the students have service obligations at the hospital for a specific period of time ranging from 2 to 5 years. Between FY 2008 and FY2010, hospitals provided support to program participants pursuing the following degrees:

- 488 LPN or Associate degrees in Nursing
- 782 BSN degrees
- 95 MSN degrees

Maryland hospitals have also encouraged nursing staff to improve their competencies through professional certifications. Approximately 2,800 nurses completed certifications in various areas including, emergency room, pain management, wound care, medical-surgical and neonatal, through the NSP I initiatives between 2008 and 2011. St. Joseph Hospital used NSP I funds to improve the percentage of nurses with professional certifications. In FY 2011, the number of nurses with professional certifications at St. Joseph Hospital increased from 7 percent to 22 percent. Mercy has also seen a dramatic increase the number of certified nurses, from 22 in FY 2007 to 146 in FY 2011, an 85 percent increase.

Reduced Nurse Vacancy and Turnover Rates

Although a direct link cannot be made between the NSP I programs and vacancy or turnover rates, statewide data show significant reductions in vacancy rates for RNs and LPNs (26 percent and 57 percent, respectively) during this NSP I cycle (Chart 3). There also seems to be a similar downward trend for turnover rates (Chart 4). LPN turnover and vacancy rates have risen in the last 3 years, possibly because of the increased push for LPNs to become RNs as opportunities for LPNs in hospitals have declined.

[5] L. H. Aiken, S.P. Clarke, R.B. Cheung, D. M. Sloane, & J.H. Silber. Educational Levels of Hospital Nurses and Surgical Patient Mortality. Journal of the American Medical Association. 290:12 (2003). 1617-1623

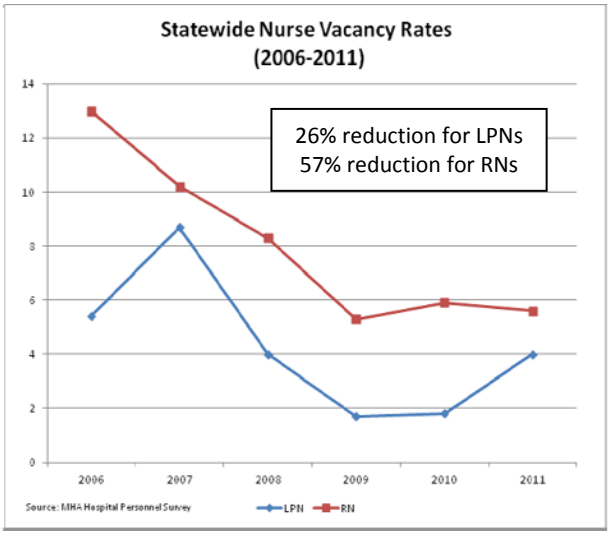


Chart 3

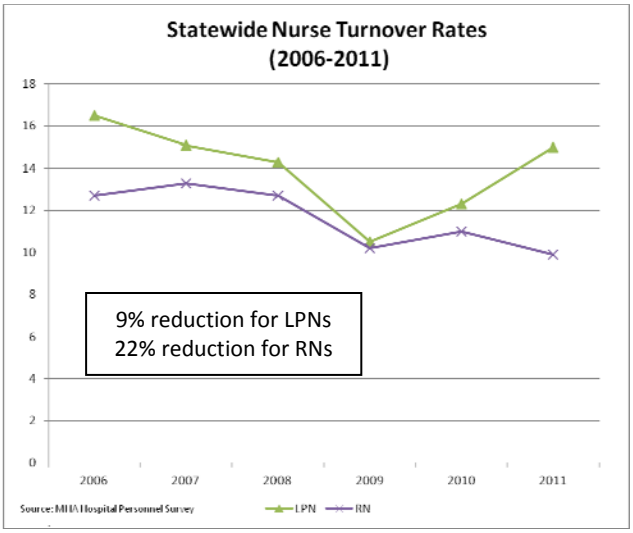


Chart 4

NSP I coordinators attribute the reduction in turnover and vacancy rates to improved nursing satisfaction. The funding provided by NSP I has enabled hospitals to promote nursing through enhanced educational opportunities, leadership development, research and joint governance. During the last 5 years, hospitals have established processes to encourage leadership development in a variety of areas. Some hospitals, like Bon Secours, have difficulty recruiting and retaining nurses because of their size or patient mix. Bon Secours invested its NSP I funds in developing an infrastructure for professional practice and engagement. The nursing leadership instituted councils that focus on three areas: professional development and improving the practice of nursing; recruitment, retention and recognition of nurses; and the lead partner's council. These councils provide nurses with a forum to communicate and collaborate with other departments. Through these efforts, Bon Secours have been able to reduce its voluntary turnover rate from 14 percent to 8 percent.

Recognized as Leaders in Nursing Excellence

The Magnet Recognition© program recognizes healthcare organizations for quality patient care, nursing excellence, and innovation in professional nursing practice. During the last 5 years, 6 hospitals have received Magnet© designation by the American Nurses Credentialing Center. These hospitals, and when they gained Magnet© status, are listed below:

- Franklin Square Hospital Center (2008)
- University of Maryland Medical Center (2009)
- Memorial Hospital of Easton (2009)
- Dorchester General Hospital (2009)
- Sinai Hospital (2009)
- Mercy Medical Center (2011)

With funding from the NSP I program, 11 more Maryland hospitals are on course to Magnet© status.

Hospital quality data collected by the HSCRC have shown a link between Magnet© hospitals and improved patient care, safety, and satisfaction. For FY2011, Maryland Magnet© hospitals had lower rates of nursing-sensitive Maryland hospital acquired complications (MHACs) than non-Magnet© Maryland hospitals.

Nursing Sensitive Hospital-Acquired Complications, FY 2011
Risk Adjusted Complication Rates per 1,000 admission
Source: 3M Potentially Preventable Complications (PPC) Grouper using HSCRC FY2011 Abstract Data

MHAC Measure	Magnet Hospitals	Non-Magnet Hospitals	Difference
PPC 31: Decibutus Ulcer	1.11	1.54	-27.92%
PPC 28: In-Hospital Trauma and Fractures*	0.06	0.21	-71.43%

***Statistically Significant**

On the Hospital Care Quality Information from the Consumer Perspective (HCAHPC), for CY 2010, Maryland Magnet© hospitals tended to score higher on indicators of patient satisfaction than non- Magnet© hospitals.

Patient Experience of Care Measures, CY 2010
Source: HCAHPS

HCAHPS Measure	Magnet Hospitals	Non-Magnet Hospitals	Difference
Communication About Medicines (Q16-Q17)*	63.4%	57.0%	6.45%
Communication With Nurses (Q1-Q3)	80.4%	75.8%	4.60%
Discharge Information (Q19-Q20)*	86.2%	80.9%	5.35%
Responsiveness of Hospital Staff (Q4,Q11)*	63.2%	56.7%	6.54%
Communication With Doctors (Q5-Q7)	80.8%	77.8%	3.00%
Pain Management (Q13-Q14)	70.2%	67.1%	3.05%
Cleanliness of Hospital Environment	65.6%	64.1%	1.50%
Quietness of Hospital Environment	54.2%	53.7%	0.52%
Willingness to Recommend this Hospital	72.2%	66.0%	6.25%
Overall Rating of this Hospital	70.8%	64.7%	6.14%
HCAHPS score in QBR for FY2012 Rates*	65.4%	37.1%	28.30%

*Statistically Significant

The Future of Nursing: IOM Recommendations

In 2010, the Institute of Medicine (IOM) published a groundbreaking report based on a two year initiative to respond to the need to assess and transform the nursing profession. The report laid out 8 recommendations to address the increasing demand for high quality and effective health care service. HSCRC Staff convened a workgroup with nursing leaders representing Sinai, Mt Washington, Anne Arundel, and MedStar hospitals, to discuss how to incorporate four of the IOM recommendations into the scope of NSP I.

IOM Recommendation 3: Implement nurse residency programs. Maryland hospitals have already engaged in components of residency programs, including mentoring and extended orientations for new hires and graduates, and by encouraging evidenced based research and competency training for hard-to fill positions. The workgroup recommended standardizing the definition of residency programs and defining specific criteria for the components. The NSP I programs should also support hospitals that desire to pursue accreditation by the Commission on Collegiate Nursing Education (CCNE), an autonomous accreditation body that ensures the quality and integrity of baccalaureate, graduate, and residency programs in nursing.

IOM Recommendation 4: Increase the proportion of nurses with a baccalaureate degree to 80 percent by 2020. As reported above, Maryland hospitals are supporting nurses who are pursuing advanced degrees, but data are not consistently reported. The workgroup suggested that statewide targets be set for the number of nurses graduating with advanced degrees and that metrics be defined to track progress.

IOM Recommendation 6: Ensure that nurses engage in lifelong learning. Maryland hospitals are already sponsoring continuing education opportunities for their nursing staff. Examples of NSP I funded activities include: sending their nurses to national conferences, specialty training, and establishing simulation labs to improve the competency of their nursing staff. The NSP I program will continue to support these activities that will prepare Maryland's nursing workforce to provide "care for diverse populations across the lifespan."[6]

IOM Recommendation 7: Prepare and enable nurses to lead change to advance health. Data from the Wage and Salary survey show a slight increase in the number of nurse managers during this NSP I cycle. With an impending nurse shortage forecasted, and as the current nursing leaders retire, growing a new generation of nursing leaders is an important step in a hospitals succession planning. However, nurse management is not the only area in which staff nurses can be leaders. Hospitals currently support many avenues for leadership. These include, clinical ladders, nurse champions in specialty areas, such as wound care, mentors, preceptors and educators, as well as management training. The NSP I program will continue to support programs that provide opportunities for nurses to develop leadership skills.

[6] Institute of Medicine of the National Academies. The Future of Nursing: Leading Change, Advancing Health. (2010)

Staff Recommendations: Moving Toward Nursing Excellence

In preparing for this recommendation, HSCRC staff convened two NSP I Coordinator meetings to obtain feedback about NSP I, particularly regarding modifications to the program that will enable hospitals and staff to clearly demonstrate the value of the program. Based on these discussions, HSCRC staff recommends renewing the NSP I program for another 5 year cycle, with the modifications described in the following recommendations.

Revise focus of NSP I Program

Evidence has shown that nursing excellence is linked to improved patient outcomes, low nursing turnover, and increased satisfaction among nursing staff. Incorporating the IOM recommendations into the scope of the NSP I program provides guidance to move all hospitals toward nursing excellence.

Recommendation 1: In an effort to raise the bar for Maryland nurses, the NSP I program should focus on three areas to achieve nursing excellence for all hospitals in Maryland:

- **Education and career advancement.** The NSP I program will set statewide targets for the number of advance degree nurses, collect standardized metrics for educational attainment, and define and collect data on leadership initiatives and succession planning.
- **Patient quality and satisfaction.** The NSP I program will utilize existing nursing sensitive metrics to demonstrate the link between improved nursing competency and better patient outcomes.
- **Advancing the practice of nursing.** The NSP I program will continue to support activities that advance the practice of nursing, such as staff driven evidenced-based research in nursing, attendance at symposiums and research conferences, as well as achieving or maintaining Magnet status.

Improved Application Process

Since the NSP I program is non-competitive, it is unnecessary to have a formal application process.

Recommendation 2: Instead of a formal application, hospitals will submit Letters of Commitment that describe their program and how they would report metrics to demonstrate program progress and outcomes. Staff, with input from hospital industry, will develop guidelines for the letters that outline reporting and compliance expectations. If hospitals need to revise their programs, there will be a process for submitting changes for review and approval.

Revise Annual Report and Budget Form

In an effort to move away from qualitative data, HSCRC developed a quantitative data collection tool that was capable of capturing outcomes from the varying programs implemented by hospitals. Unfortunately, this created a different problem; HSCRC staff received a large amount of data that still did not capture outcomes of the programs in a consistent way. There were a few metrics that could demonstrate outcome, such as vacancy and turnover rates; however, hospitals did not complete the data consistently, and the data could not be verified by other sources. In addition, tracking how NSP I funds were spent continued to be a challenging task. HSCRC review found several instances where hospitals had unfilled staff positions, but reported spending all the budgeted

funds without indication of where the hospital redirected the funds budgeted for the unfilled positions. Hospitals did not report expenditures consistently, making it difficult for HSCRC staff to track and audit hospitals' use of NSP I funds. For FY 2011, hospitals spent 14 percent of their budgeted funds on "Other Expenses" that ranged from NCLEX Preparation courses to travel costs for staff.

> **Recommendation 3:** The annual report should contain 5-10 focused metrics that are well-defined and can be consistently reported by hospitals. Staff will also use datasets that hospitals are already reporting to the HSCRC, such as the Wage and Salary survey, as well as quality metrics such as the MHACs and HCAHPC. HSCRC staff will revise the budget form to better track hospitals expenditures related to the NSP I program.

Improve Monitoring and Oversight

As stated above, monitoring the NSP I program has been challenging. Outside of the annual reports and budget submission, communication with HSCRC staff and with other NSP I coordinators has been minimal.

> **Recommendation 4:** HSCRC staff will improve oversight and monitoring of the NSP I program through:
>
> - Routine site visits at hospitals (began already in FY 2012)
> - Include NSP I budgets with the special audits

HSCRC staff will convene a Steering Committee, consisting of nursing and finance staff from the hospitals, to develop concise metrics, develop guidelines for commitment letters, and revise data submission forms.

Nurse Support Program I:

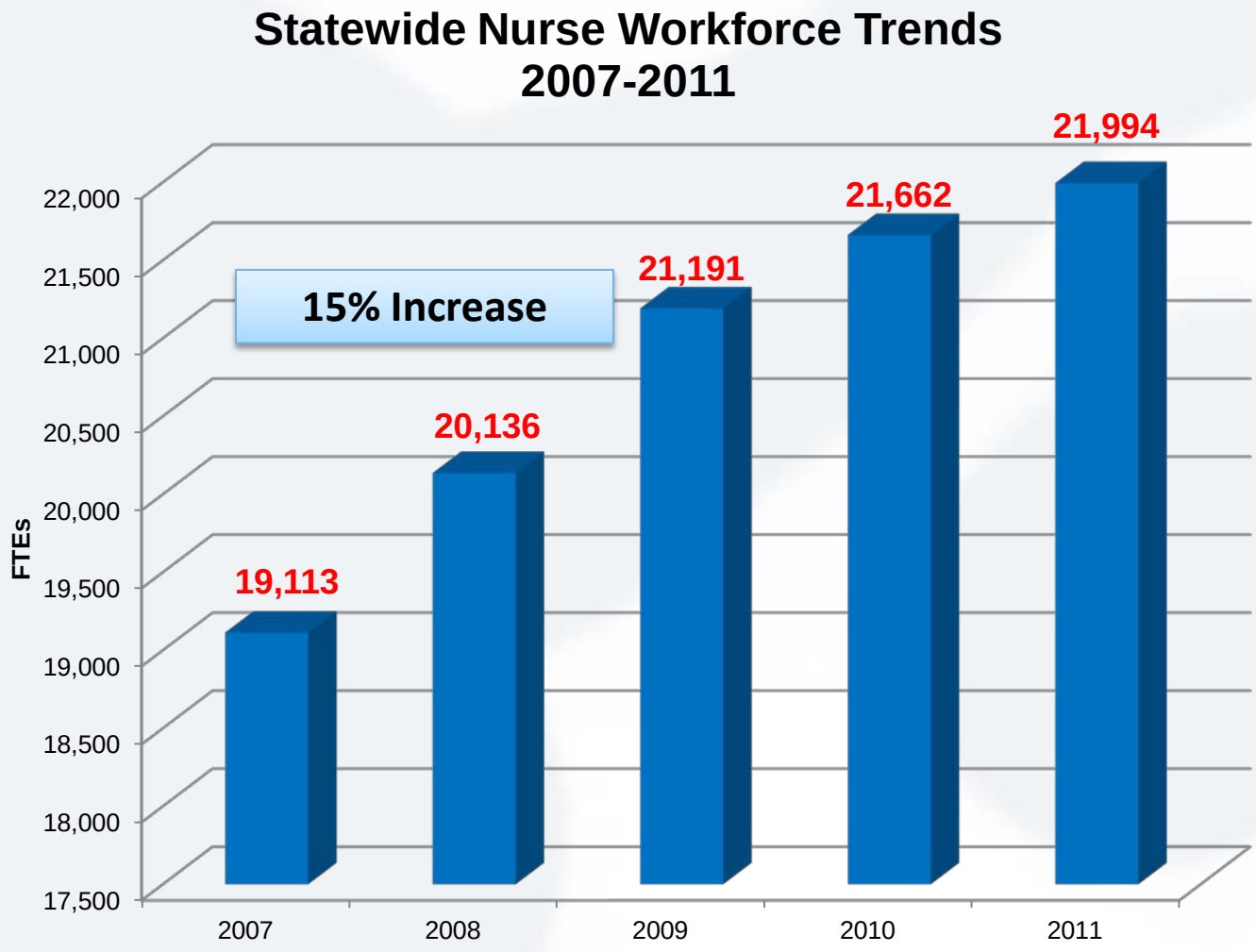
Shaping the Future of the Nurse Workforce in Maryland

What is the Nurse Support Program I?

The Nurse Support Program I (NSP I) was initiated to increase the number of bedside nurses through support of educational attainment, retention and recruitment initiatives and improvement of the nursing environment.

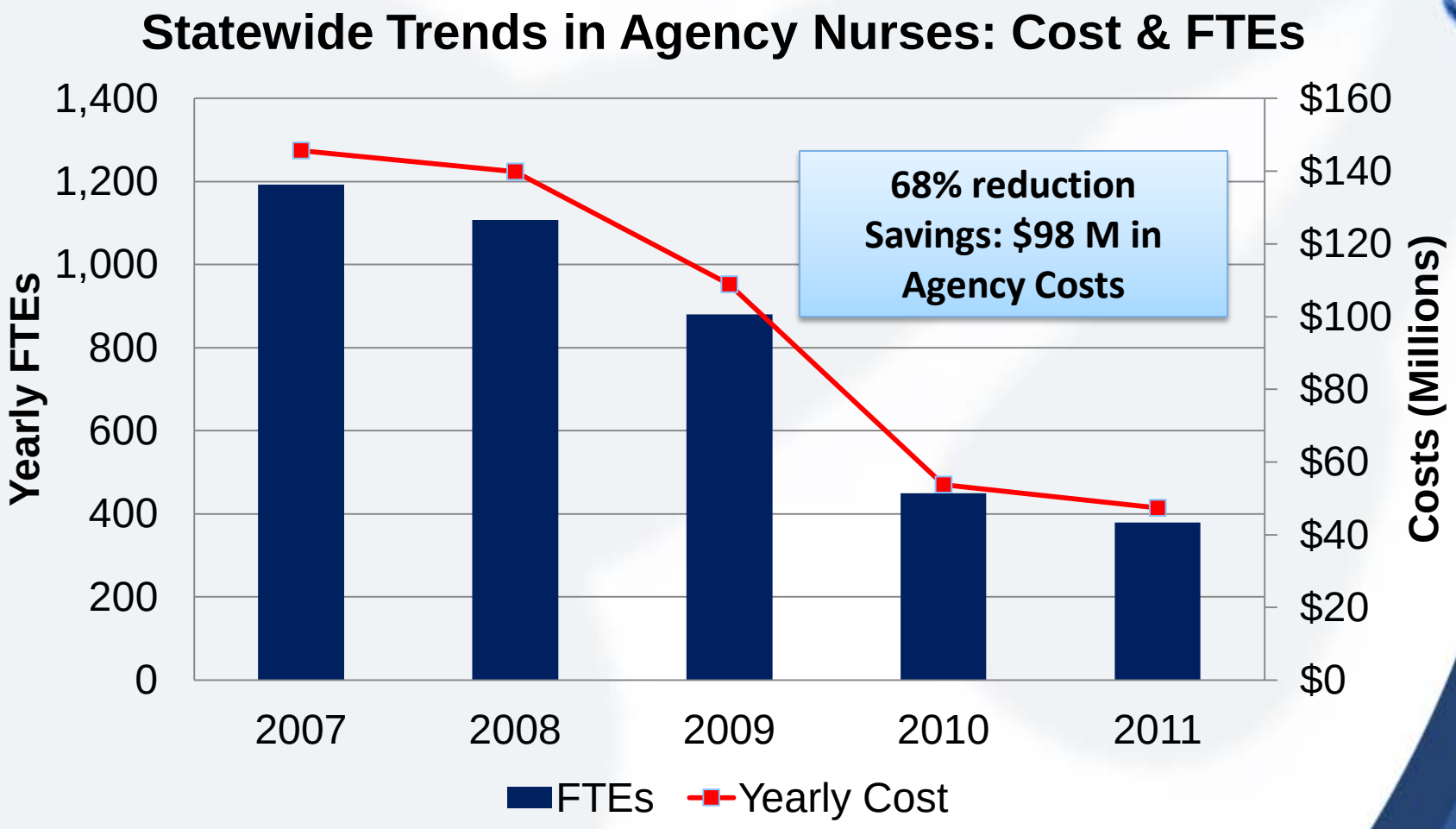
What Have We Accomplished?

Increased the Number of Bedside Nurses



Source: HSCRC Wage & Salary Survey

Reduced Dependence on Agency Nurses



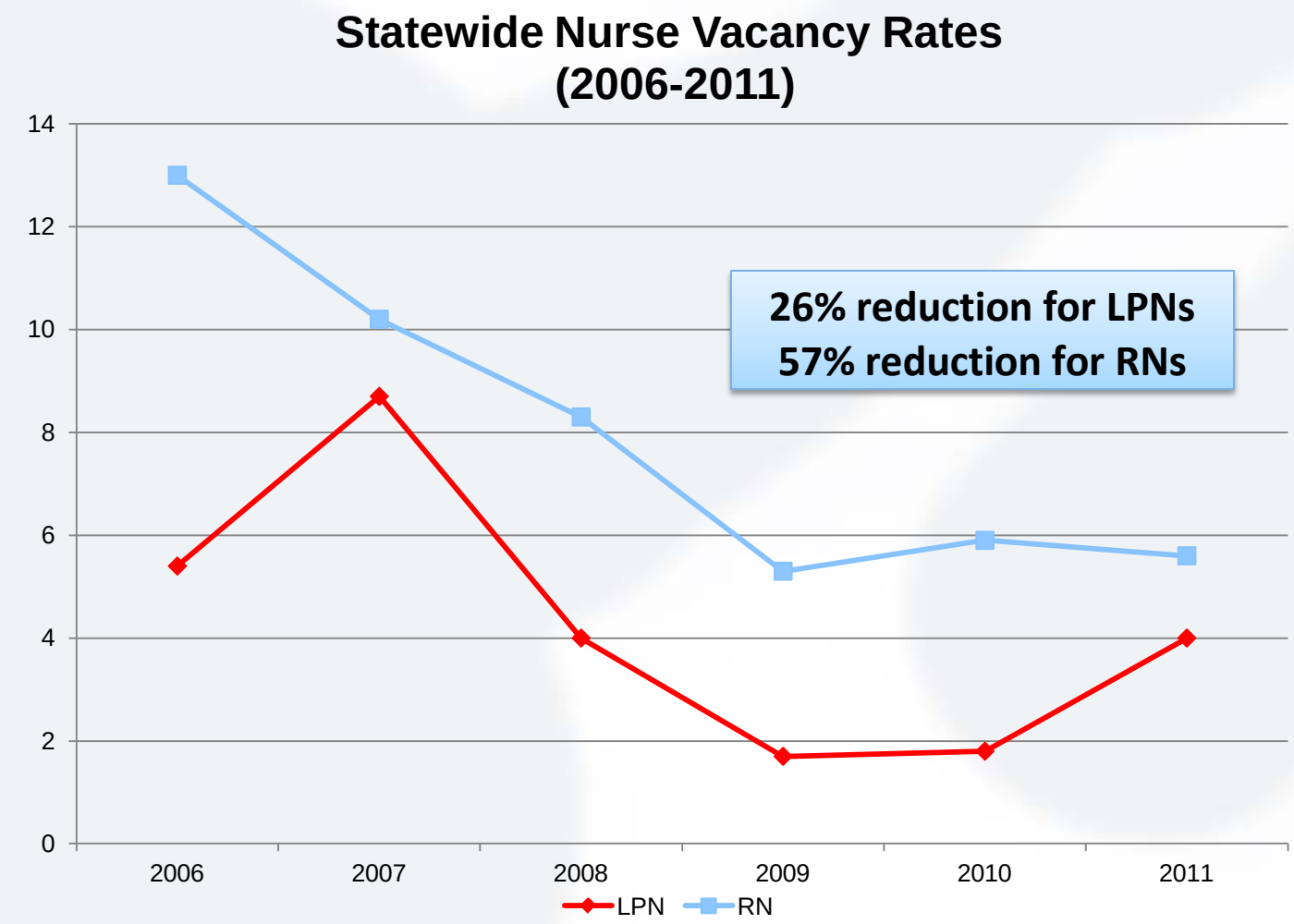
Source: HSCRC Wage and Salary Survey

Increased the Number of Certified and Advanced Degree Nurses

Between 2008 and 2011:

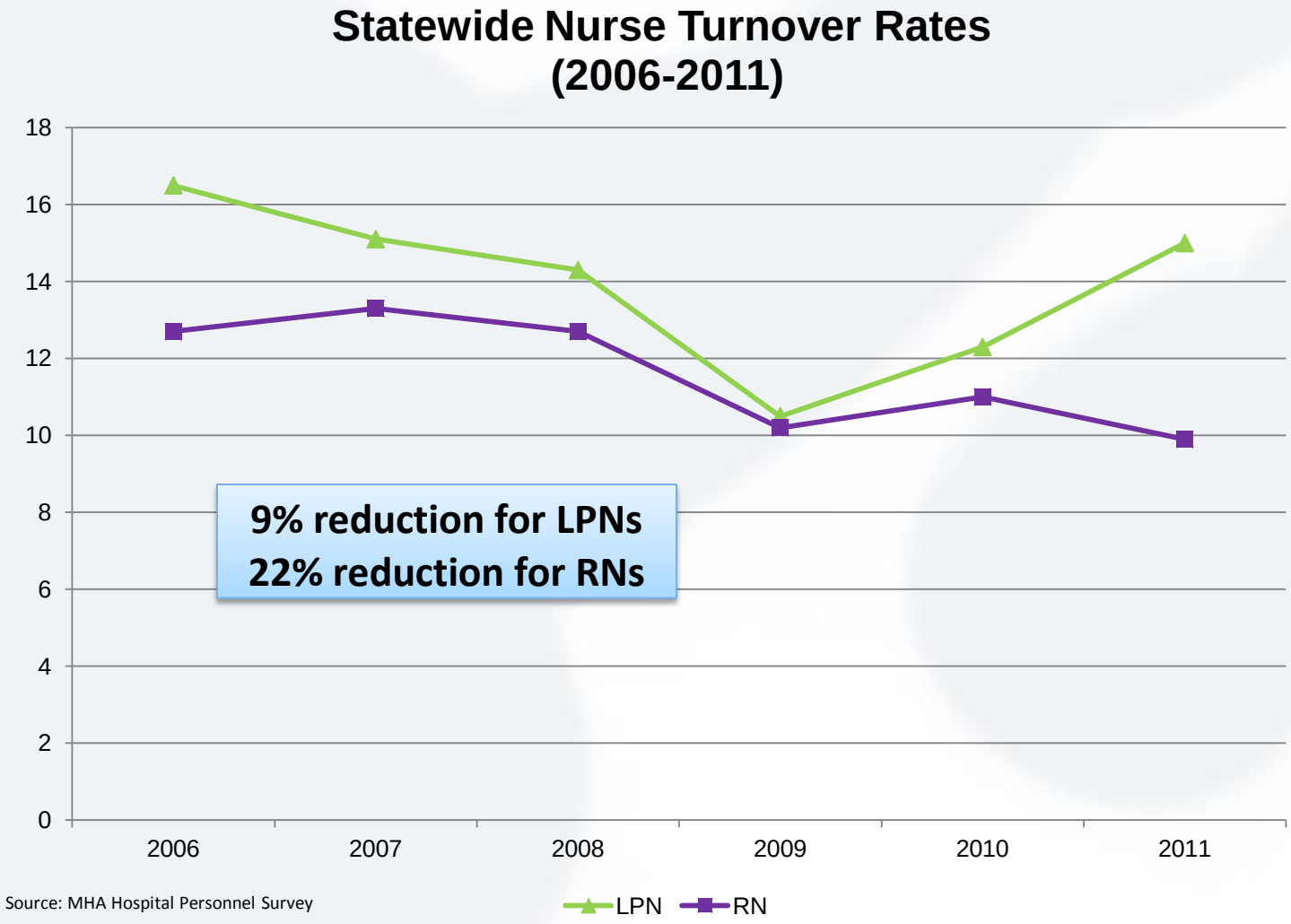
- Hospitals provided $8.5M of NSP I funding on scholarships and tuition – 64% for nursing staff employed at the hospital
- Supported participants pursuing
  - 488 LPN or Associate degrees in Nursing
  - 782 BSN degrees
  - 95 MSN degrees
- 2,800 nurses completed specialty certifications

Decreased Nurse Vacancy Rates



Source: MHA Hospital Personnel Survey

Decreased Nurse Turnover Rates



Source: MHA Hospital Personnel Survey

Maryland Hospitals Were Recognized as Leaders in Nursing Excellence

- Johns Hopkins (2003)
- Franklin Square (2008)
- University of MD (2009)
- Dorchester (2009)
- Memorial Hospital of Easton (2009)
- Sinai (2009)
- Mercy (2011)
- 11 more hospitals on the path to Magnet Status

MHACs Show Links Between Nursing Excellence and Patient Outcomes

Nursing Sensitive Hospital-Acquired Complications, FY 2011 Risk Adjusted Complication Rates per 1,000 admission			
	Magnet Hospitals	Non-Magnet Hospitals	Difference
PPC 31: Decibutus Ulcer	1.11	1.54	-27.92%
PPC 28: In-Hospital Trauma and Fractures*	0.06	0.21	-71.43%
*Statistically Significant			

Source: 3M Potentially Preventable Complications (PPC) Grouper using HSCRC FY11 Abstract Data

HCAHPS Show Link Between Nursing Excellence and Patient Satisfaction

Patient Experience of Care Measures, CY 2010 Source: HCAHPS			
HCAHPC Measure	Magnet Hospitals	Non-Magnet Hospitals	Difference
Communication About Medicines (Q16-Q17)*	63.4%	57.0%	6.45%
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Pain Management (Q13-Q14)	70.2%	67.1%	3.05%
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HCAHPS Show Link Between Nursing Excellence and Patient Satisfaction

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HCAHPS SCORE IN QBR for FY2012 Rates*	65.4%	37.1%	28.30%
Cleanliness of Hospital Environment	65.6%	64.1%	1.50%
Quietness of Hospital Environment	54.2%	53.7%	0.52%
Willingness to Recommend this Hospital	72.2%	66.0%	6.25%
Overall Rating of this Hospital	70.8%	64.7%	6.14%
*Statistically Significant			

The Future of NSP I:

Institute of Medicine (IOM) Recommendations

In 2010, IOM Laid Out Blueprint for Future of Nursing

- Eight recommendations to transform the nursing profession
  - Address increasing demand for high quality, effective health care services
  - Focus on improving nursing education, leadership and data collection
- Staff met with hospital nursing leaders to discuss how to incorporate recommendations in NSP I

Four IOM Recommendations Fit into NSP I Scope

- ***IOM Recommendation 3:*** Implement nurse residency programs
- ***IOM Recommendation 4:*** Increase the proportion of nurses with a baccalaureate degree to 80 percent by 2020
- ***IOM Recommendation 6:*** Ensure that nurses engage in lifelong learning
- ***IOM Recommendation 7:*** Prepare and enable nurses to lead change to advance health

Staff Recommendations:

Moving Toward Nursing Excellence

Based on discussions with NSP I Coordinators and other leaders in nursing, HSCRC staff recommends renewing the NSP I program for another 5 year cycle, with the modifications described in the following recommendations.

Recommendation 1: Revise focus of NSP I

Follow IOM's lead and focus NSP I on three areas aimed at achieving nursing excellence:

- Education and career advancement
- Patient quality and satisfaction
- Advancing the practice of nursing

Recommendation 2: Improve NSP I Application Process

- Require each participating hospital to write a letter of commitment describing the program and how metrics will be reported
- Develop NSP I reporting requirements and compliance expectations
- Develop process for submitting program changes for review and approval

Recommendation 3:
Revise Annual and Budget Reporting

- Hospitals to report 5-10 focused metrics that are well-defined and can be consistently reported
- Use data already being reported to the HSCRC, such as the Wage and Salary survey, as well as quality metrics such as the MHACs and HCAHPS
- Revise the budget form to better track expenditures

Recommendation 4: Improve Monitoring and Oversight

- HSCRC staff will continue routine site visits at hospitals (began already in FY 2012)
- Include the review of NSP I budgets as part of the annual special audits

Preliminary Timeline

Jun 6: Draft Recommendations to Commission

Jul 11: Final Recommendations to the Commission

Jun - Oct: Convene Steering Committee

- Commitment Letters and budgets
- Metrics
- Proposal materials

Preliminary Timeline, Cont.

Early- Aug: Submit Commitment Letters & budgets

Nov: NSP I Coordinators Meeting

Dec: Submit proposals

Jan 2013: Review proposals

May-Jul: Convene Steering Committee

- Revise Annual Report

Jun: NSP I Coordinators Meeting

Sept: Submit FY13 Annual Reports

Questions & Discussion

Averted Bad Debt:
Options for Reconciliation of FY 2011 Averted Bad Debt Estimates to Actual and Averted Bad Debt Policies for FY 2012 and Beyond

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
410-764-2605

June 6, 2012

These draft options are for Commission consideration at the June 6, 2012 Public Commission Meeting. No action is required.

Purpose

This recommendation discusses decision points related to the reconciliation of averted bad debt estimates to actual for FY 2011. This recommendation also proposes policies related to reconciling the Medicaid expansion uniform assessment in FY 2012 and beyond.

HSCRC staff has engaged Maryland Medicaid, hospital, and payer representatives to discuss averted bad debt reconciliation. While our efforts are continuing, our process thus far has included discussions with the individual parties, provision of hospital discharge data to Medicaid, review of information provided by the Maryland Medicaid, and the facilitation of an in-person meeting among the interested parties.

FY 2011

Similar to FY 2010, the amount of "actual" averted bad debt in FY 2011 is less than the amount paid by hospitals to Maryland Medicaid. While hospital and Medicaid staff have not yet reached agreement on the final dollar amount to be reconciled, when HSCRC staff applies the same reconciliation assumptions as in FY 2010 and projects the final claims run-out (claims submitted to Medicaid after the fiscal year ends) based on FY 2010 run-out, we calculate the estimated final averted bad debt reconciliation amount as $30.0 million.

In determining the final averted bad debt reconciliation amount for FY 2011, the major discussion points are:

1. Refine the assumptions to project the final claims run-out amount
2. Review and potentially alter the crowd out rate and lower use rate adjustment factors to calculate the resulting "actual" averted bad debt
3. Determine the most appropriate means of reconciling the difference between the amount paid by the hospitals to Maryland Medicaid and actual averted bad debt

FY 2012

Before FY 2012, Maryland Medicaid and the HSCRC calculated the amount of averted bad debt to be built into rates based on expected amounts of program expenditures for the upcoming fiscal year. As the program reached a near steady-state, changes to State statute implemented for FY 2012 rates locked the amount of revenue allocated for the Medicaid expansion at uniform assessment of 1.25 percent of projected regulated net patient revenue for each hospital.[1] With a fixed percentage built into rates, policy no longer requires HSCRC staff to reconcile expected to actual averted bad debt between the hospitals and Maryland Medicaid. However, HSCRC staff anticipates reconciling among hospitals at the close of FY 2012 - FY 2014 .

To determine an inter-hospital reconciliation approach for FY 2012 and beyond, HSCRC staff requested input from hospitals.

Recent Commission Actions

The most recent Commission action regarding averted bad debt was on October 12, 2011 involving the reconciliation of averted bad debt estimates to actual for FY 2010.

[1] Health - General Article 19-214(d)(2)(i)

Background

In 2007, the General Assembly enacted Chapter 7 of the Laws of Maryland, The Working Families and Small Business Health Coverage Act (The 2007 Act), which expands access to health care in a number of ways, including expanding Medicaid eligibility to parents and caretaker relatives with household income up to 116 percent of the federal poverty guidelines (FPG), an increase from 46 percent FPG, beginning in FY 2009. A component of the 2007 Act also provided for Board of Public Works actions in July 2009 to add emergency services to Medicaid's Primary Adult Care (PAC) program, a program that provides a limited benefit package of health services to non-parental adults. Special funds, including savings from averted uncompensated care, cover a portion of the costs of these expansions.

FY 2011 Reconciliation

Determination of the Averted Bad Debt Assessment Amount in FY 2011

When establishing the FY 2011 hospital rates, HSCRC staff worked with Maryland Medicaid staff to arrive at a total amount of bad debt that was expected to be averted during the upcoming fiscal year as a result of the Medicaid expansion. Maryland Medicaid provided HSCRC staff with expected enrollment, per member/per month costs, and total expenditures. Commission staff then adjusted the expected total Medicaid expansion expenditure amount to reflect out-of-state admissions, the estimated percentage of Medicaid expansion expenditures that would accrue to hospitals (as opposed to other providers or service components), the crowd-out rate, and the lower use rate.

The product of this calculation resulted in a total amount that HSCRC staff differentially removed from the uncompensated care amounts across all hospitals for FY 2011. The amount removed for each hospital is based on the proportion of Medicaid's expenditures for this type of population at each hospital.

Since State statute requires the assessment to be uniform and broad-based, the Commission added back to the rates of all hospitals an equal percentage that represents the total estimated averted bad debt amount. Any portion that is not added back to rates will reduce rates over all, resulting in savings to purchasers/payers of hospital care. For FY 2011, HSCRC staff calculations built in no savings to purchasers/payers of care in the uniform assessment. Table 1 illustrates the calculations used for establishing the expected averted bad debt and assessment amount for Medicaid and PAC for FY 2011.

Table 1: Medicaid Expansion FY 2011 Expected Averted Bad Debt Calculations (In Millions)

Calculation of Estimated Reduction to Hospital Uncompensated Care		
	Medicaid	**PAC**
DHMH Estimated Expansion Expenditures	$457.6	$25.2
Payments Made Inside of Maryland (Medicaid -6%, PAC 0%)	$430.2	$25.2
Hospital Gross Charges (Medicaid pays 94% of Charges)	$457.6	$26.8
Percent Paid to Maryland Hospitals (Medicaid 47.61%, PAC 100%)	$217.8	$26.8
Medicaid Less: Crowd Out (-28%) and Lower Use Rate (-18%) PAC: No Assumptions	*-$89.2*	*$0*
Hospital Rates Estimated Reduction for Uncompensated Care*	**$128.6**	**$26.8**

Calculation of Payment Made to DHMH	
	Medicaid & PAC
Estimated Reduction to Hospital Rates for Uncompensated Care	$155.4
Savings Provided to Payer (0%)	$0
*Amount Paid to Medicaid (94%)***	**$146.1**

Notes: *Numbers in table may not sum due to rounding*

* A portion of this amount was allocated to each hospital based on the percentage of current Medicaid payments made to the hospital for this type of population. The allocated amount for each hospital was used to calculate a percent of revenue which was then used to reduce each hospital's approved UCC. The reduced UCC was used in each hospital's calculation of approved markup, and Approved Revenue was reduced accordingly.

** A portion of this amount was uniformly allocated to each hospital based on its estimated Approved Revenue for FY 2011. Each hospital made monthly payments to DHMH throughout the year.

*** HSCRC staff calculated the FY 2011 uniform assessment prior to decisions made in October 2011 to alter the crowd out rate assumption from 28% to 18%.

Determining the Total Charges for Medicaid Expansion Population in FY 2011

The reconciliation process is designed to determine the amount that hospitals actually received in payments for the Medicaid expansion population and PAC emergency department service coverage expansion and to calculate the resulting reduction to UCC from these programs. HSCRC staff compares this UCC reduction to the amount that the HSCRC prospectively removed from the UCC component of each hospital's rate to determine any discrepancies between the estimated and actual amounts.

Ideally, HSCRC staff could rapidly ascertain the actual payments for the Medicaid expansion population using one data source. Unfortunately, no one data source provides all information needed for this calculation. Instead, Maryland Medicaid, HSCRC, and hospital staff worked together in an iterative process to supply, compare, and merge data from three major sources. This merging process has proven challenging for all involved.

Currently, HSCRC staff has completed the merging process for data through March 31 2012. With only three months of run-out remaining, Medicaid charges are at $139.2 million and PAC charges are at $27.9 million.

Final run-out for FY 2011 is not yet complete. However, based on past reconciliations, HSCRC has projected the dollar value of the Medicaid run-out at $1.4 million.

Interested parties are discussing the most effective and efficient way to consider the run-out. Options include:

1. Complete a preliminary averted bad debt settlement now using projected run-out; finalize the settlement with all run-out claims (approximately October)
2. Finalize the averted bad debt settlement now using projected run-out

In considering these options, interested parties are taking into account a number of considerations, including staff resources used in the encounter data reconciliation process, the timing of HSCRC issuing the FY 2013 rate orders, and the potential inaccuracy of the run-out projection.

Applying Crowd Out and Lower Use Rates to Determine Actual Averted Bad Debt in FY 2011

Once interested parties have agreed on the most efficient plan to include the run-out, Commission staff will sum total charges for the Medicaid expansion population for each hospital. HSCRC staff then calculates the actual UCC by applying the crowd out and lower use rate estimates to these total charges. Note that for purposes of this recommendation, we refer to this amount as the "actual" reduction to UCC resulting from the Medicaid expansion. In practice, however, there is a continued amount of estimation involved in the calculation as the crowd-out and lower use rates applied to the total charges are themselves estimates.

In our first meeting with Maryland Medicaid and hospital staff, interested parties have initially agreed to continue to employ the 18.22 percent crowd out rate agreed upon during the FY 2010 averted bad debt reconciliation.

Maryland Medicaid staff has also discussed the lower use rate with the interested parties. In calculating the estimated reduction to hospital uncompensated care, HSCRC employed a lower use rate of 18 percent. In our initial meetings, Maryland Medicaid staff advocated reducing the lower use rate based on the observed difference between the growth in Medicaid expansion enrollment and the percent growth seen in hospital charges between FY 2010 and FY 2011. See Table 3. Interested parties are continuing to discuss the lower use rate assumption.

HSCRC staff conducted sensitivity testing around the potential reduction in the lower use rate. For every percentage point change in the lower use rates, we calculate a corresponding change of $1.1 million to actual averted bad debt. For example, if the HSCRC reduces the lower use rate from 18 percent to 9 percent, we see actual averted bad debt increase by approximately $10 million (i.e., the total dollar of the amount to be reconciled decreases by 10 million).

Table 3: Medicaid Expansion Population and Hospital Charges Growth

	Enrollment	Expansion Population Hospital Charges
FY 2010	54,922	$125.5 million
FY 2011	72,838	$140.6 million*
Percent Change	25%	11%

* FY 2011 is actual charges through the end of March, April - June charges projected.

Calculation of Overpayments/Underpayments to Maryland Medicaid for FY 2011

Assuming a run-out of $1.4 million, HSCRC staff finds total Medicaid charges in FY 2011 at $140.7. Appling the crowd out rate (18.22 percent) and lower use rate (18 percent) used in FY 2010, HSCRC staff calculates the actual reduction to bad debt as $95.6 million. For PAC, the FY 2011 charges are $27.9.3 million. HSCRC staff applies no crowd out or lower use rate assumptions to PAC. As shown in Table 4, the net aggregate difference in what was paid by hospitals to Maryland Medicaid in the form of a uniform assessment, and the amount paid by Maryland Medicaid to hospitals for this population is $30.0 million.

Since the assessment was applied as a uniform percentage of revenue, the Commission also calculates the difference in the assessment amount and the actual amount of Medicaid payments for the expansion population. The Commission then adjusts the uncompensated care provision of hospitals to reflect this difference.

Table 4: Medicaid Expansion FY 2011 Reconciliation of Actual Averted Bad Debt (In Millions)

Calculation of Actual Averted Bad Debt		
	Medicaid	**PAC**
Reduction to Hospital Rates for Uncompensated Care	$158.3	
Total Hospital Charges to the Expansion	$140.7	$27.9
Medicaid Less: Crowd Out (-18.22%) and Lower Use Rate (-18%) PAC: No Assumptions	$45.1	$0
Actual Reduction to Uncompensated Care Due to Expansion	$95.6	$27.9
Calculation of Overpayment/Underpayment to DHMH		
	Medicaid & PAC	
Actual Reduction to Uncompensated Care Due to Expansion	$123.5	
Amount Paid by Medicaid to Hospitals (94%)	$116.1	
Amount Paid to Medicaid by Hospitals	$146.1	
Difference	***$30.0***	

Notes: *Numbers in table may not sum due to rounding*

Options for FY 2011 Reconciliation

Based on the hospital claims reconciliations, HSCRC staff calculated a $30.0 million difference in the FY 2011 actual and assessment amounts associated with averted bad debt for Medicaid and PAC. Below are several reconciliation options that interested parties will be discussing and for which Commission staff seek comments:

- Option 1 – Reduce Future Assessment Payments to the Department
- Option 2 – Increase Hospital Rates in FY 2012 to Reflect the Overpayment Amount
- Option 3 – Take No Action to Alter the Averted Bad Debt Estimated or Assessment Amounts in Future Years
- Option 4 – Adopt a Combination of Any of Options 1 through 3

Averted Bad Debt Policy for FY 2012 and Beyond

As discussed in the background section of this recommendation, HSCRC now applies a fixed uniform assessment of 1.25 percent in hospital rates. In FY 2012 and beyond, policy no longer requires reconciliation between Maryland Medicaid and hospitals.

However, HSCRC staff has discussed with interested parties the option to settle averted bad debt among hospitals for purposes of determining the uncompensated care pooling amounts in FY 2012 through FY 2014. Several options discussed include:

- Not reconciling among hospitals
- Reconciling among hospitals using a fixed percentage
- Continuing the encounter data reconciliation process and reconciling to actual averted bad debt

HSCRC staff will continue discussions with interested parties with the intent to bring to the next Commission meeting a final recommendation for averted bad debt for FY 2012 and beyond.

Averted Bad Debt: Decision Points for FY 2011 Reconciliation and Policies for FY 2012 and Beyond

HSCRC staff will work with interested parties over the next few weeks with the intent to reach consensus on the following decision points:

- Decision Point 1, FY 2011 - With an understanding of the rate order production schedule, determine the most effective and efficient means to account for the FY 2011 run-out
- Decision Point 2, FY 2011 – Identify the best representative lower use rate
- Decision Point 3, FY 2011 – Determine how to reconcile FY 2011 averted bad debt
- Decision Point 4, FY 2012 and beyond – Develop a policy to reconcile among hospitals

Medicaid Assessments and Hospital Related Cost-Containment Measures for FY2013

June 6, 2012

The FY2013 Medicaid budget increased the Medicaid deficit assessment by $24 million, from $389 million to $413 million in FY 13. The total Medicaid deficit assessment now represents about 2.6 percentage points on the Medicare waiver test. In addition to this assessment, the FY2013 Medicaid Budget required that Medicaid cost containment measures relating to hospitals will save an additional $75 million in Medicaid costs, as follows:

- Tiering Outpatient Clinic and Emergency Services - $30 million General Funds (GF), $60 million total funds
- Pooling Disproportionate Share - $9.1 million GF, $18.2 million total
- Reducing Payment for Medically Needy Population - $36 million GF, $72 million total

In all, the Medicaid budget required additional savings from hospital-related policies of $99 million ($24 million in additional Medicaid Deficit Assessment + $75 million in cost containment measures)

The Medicaid budget assumed that the HSCRC annual update factor will be 3.8% on inpatient services, and 4.65% on outpatient services, for a combined increase of 4.13%. This was identical to the update factor impact from FY2011 to FY2012. Under these assumptions, Medicaid will achieve savings in FY2013, and these savings may be applied to the $99 million savings/additional assessment required in the budget. For each 1% below the 4.13% assumed by the Program, Medicaid is expected to achieve State savings of approximately $14 million.

To meet the legislative requirements regarding assessments and savings for the Medicaid program, the Commission authorized tiering of outpatient rates for the emergency room and clinics. The Department of Health and Mental Hygiene (DHMH) estimates that tiering will result in Medicaid savings of $30 million for FY2013. The staff is currently preparing a memorandum calling for hospitals to submit plans for tiering Emergency Department rates and Clinic rates and to provide appropriate documentation on underlying costs that justify the tiered rates.

In March 2012, the Commission authorized a reallocation of revenue from inpatient routine centers to outpatient to capture shifts in patterns of care not reflected in the cost reports used to establish FY2012 rates. While this action was designed to reduce the average charge per Medicare discharge, it also had the effect of reducing the average charge per Medicaid discharge. The reduction in Medicaid hospital expenditures due to enhanced rate realignment is $13.7 million dollars (see the attached calculation in Table 1). The Medicaid program should generate six months worth of these savings in FY2012 as well.

At the May 2012 meeting, the Commission approved an update to rates for FY2013. For inpatient rates, the approved update was -1 percent to inpatient charge per case, and outpatient rates would increase by 2.59 percent. At current volumes, this action will result in an increase in hospital revenue of 0.3 percent in FY2013, well below the 4.13 percent budgeted by DHMH. Each percentage point reduction in the update factor below the budgeted amount is expected to

save the Medicaid program $14 million. The approved update factor would then save Medicaid $53.6 million from the spending proposed in the FY2013 budget.

Table 2: Summary of Medicaid Funding Analysis

Required Medicaid Savings/Assessments		$99,000,000
Savings from tiering	($30,000,000)	
Savings from rate realignment	($13,713,086)	
Savings from lower update factor	($53,620,000)	
Total Savings		($97,333,086)
Required funding to Medicaid		$1,666,914

The actions taken by the Commission fund $97.3 million of the $99 million included in the FY2013 budget, leaving $1.7 million to be covered. Because of the thin waiver margins anticipated for FY2013, the staff recommends that this amount be paid by hospitals directly and not be included in rates. Increases in outpatient volume are likely to fund this increase.

Recommendation: Assessments paid directly to Medicaid by hospitals will be increased by $1,666,914 in FY2013, totaling $58,142,798 for the fiscal year.

Table 1: Impact of Rate Order Changes on Medicaid Revenue

Rate Center		Medicaid Revenue as a % of Total Revenue		July 1, 2011 Rate Orders Medicaid Only			January 1, 2012 Rate Orders Medicaid Only			Medicaid Impact		
		Inpatient	Outpatient	IP Revenue	OP Revenue	Total Revenue	IP Revenue	OP Revenue	Total Revenue	IP Revenue	OP Revenue	Total Revenue
MSG	Med./Surg. Acute	14.2%	24.4%	$293,329,363	$0	$293,329,363	$253,427,284	$0	$253,427,284	($39,902,079)	$0	($39,902,079)
PED	Pediatrics	52.0%	39.3%	57,344,855	-	57,344,855	48,654,199	-	48,654,199	(8,690,657)	-	(8,690,657)
PSY	Psychiatric Acute	35.5%	0.0%	91,420,919	-	91,420,919	81,093,342	-	81,093,342	(10,327,577)	-	(10,327,577)
OBS	Obstetric Acute	42.2%	36.2%	90,785,961	-	90,785,961	78,146,249	-	78,146,249	(12,639,712)	-	(12,639,712)
DEF	Definitive Observation	10.1%	10.0%	36,169,456	10,936	36,180,392	31,978,142	10,936	31,989,077	(4,191,315)	0	(4,191,315)
MIS	Med./Surg. ICU	13.8%	38.4%	89,678,807	-	89,678,807	78,164,008	-	78,164,008	(11,514,799)	-	(11,514,799)
CCU	Coronary Care	11.2%	13.1%	6,095,663	-	6,095,663	5,113,811	-	5,113,811	(981,852)	-	(981,852)
PIC	Pediatric ICU	56.5%	0.0%	22,280,816	-	22,280,816	18,924,579	-	18,924,579	(3,356,237)	-	(3,356,237)
NEO	Neonatal ICU	53.8%	1.8%	97,636,939	-	97,636,939	84,229,242	-	84,229,242	(13,407,697)	-	(13,407,697)
BUR	IP Burn Unit	26.7%	0.0%	2,389,381	-	2,389,381	2,072,086	-	2,072,086	(317,294)	-	(317,294)
ONC	IP Oncology Unit	14.5%	100.0%	8,915,601	-	8,915,601	7,634,009	-	7,634,009	(1,281,592)	-	(1,281,592)
NUR	Newborn Nursery	48.8%	0.0%	49,779,854	-	49,779,854	43,147,913	-	43,147,913	(6,631,941)	-	(6,631,941)
PRE	Premature Nursery	46.6%	0.0%	674,154	-	674,154	564,455	-	564,455	(109,700)	-	(109,700)
RHB	Rehabilitation	9.1%	7.9%	6,545,344	-	6,545,344	5,604,016	-	5,604,016	(941,329)	-	(941,329)
CRH	Chronic Care	46.1%	0.0%	11,779,808	-	11,779,808	10,820,080	-	10,820,080	(959,728)	-	(959,728)
EMG	Emergency Services	19.7%	30.5%	48,250,970	204,519,502	252,770,472	50,983,643	217,190,098	268,173,741	2,732,673	12,670,596	15,403,269
CL	Clinic Services	33.0%	23.7%	3,063,600	110,764,365	113,827,965	3,113,193	110,319,298	113,432,492	49,593	(445,066)	(395,473)
PDC	Psychiatric Day/Night	37.4%	43.2%	118,940	12,545,865	12,664,805	126,116	13,498,151	13,624,267	7,176	952,286	959,462
SDS	Same Day Surgery	16.2%	11.2%	100,515	20,375,082	20,475,597	107,678	21,654,501	21,762,180	7,163	1,279,420	1,286,583
OCL	Oncology Clinic	6.7%	5.1%	69,869	1,323,765	1,393,634	74,661	1,414,570	1,489,231	4,793	90,804	95,597
LIT	Lithotripsy	12.6%	9.7%	30,764	564,826	595,590	32,737	591,220	623,956	1,972	26,394	28,366
DEL	Labor and Delivery	45.1%	47.6%	102,867,238	32,242,251	135,109,488	109,018,133	33,931,477	142,949,610	6,150,895	1,689,227	7,840,122
OR	Operating Room	11.3%	12.1%	77,676,692	70,808,974	148,485,666	82,321,350	74,997,608	157,318,958	4,644,658	4,188,634	8,833,292
ANS	Anesthesiology	18.4%	16.3%	16,360,277	7,713,394	24,073,671	17,352,515	8,165,903	25,518,418	992,238	452,509	1,444,747
LAB	Laboratory	18.2%	16.7%	135,592,452	71,696,373	207,288,825	143,979,546	76,022,404	220,001,950	8,387,095	4,326,031	12,713,125
EKG	Electrocardiography	14.7%	14.9%	8,444,787	5,645,936	14,090,724	8,997,197	6,008,858	15,006,054	552,409	362,921	915,331
EEG	Electroencephalograph	14.9%	10.1%	4,430,514	6,499,077	10,929,591	4,717,355	6,875,618	11,592,973	286,841	376,541	663,382
RAD	Radiology-Diagnostic	17.5%	20.1%	40,805,909	69,270,901	110,076,810	43,300,192	73,406,462	116,706,654	2,494,283	4,135,561	6,629,844
RAT	Radiology-Therapeutic	16.0%	7.8%	1,739,359	14,363,162	16,102,521	1,809,600	15,147,073	16,956,673	70,242	783,910	854,152
NUC	Nuclear Medicine	13.9%	7.7%	4,861,159	5,871,785	10,732,944	5,169,231	6,226,215	11,395,447	308,072	354,431	662,503
CAT	CT Scanner	15.8%	14.3%	12,129,593	14,633,091	26,762,683	12,897,106	15,554,163	28,451,268	767,513	921,072	1,688,585
RES	Respiratory Therapy	20.1%	26.4%	48,375,539	3,593,195	51,968,734	51,329,518	3,785,026	55,114,544	2,953,979	191,831	3,145,810
PUL	Pulmonary	20.6%	9.2%	1,991,833	1,598,680	3,590,513	2,092,601	1,689,671	3,782,272	100,768	90,991	191,759
RDL	Renal Dialysis	14.8%	12.3%	8,201,788	70,152	8,271,939	8,685,121	74,501	8,759,622	483,334	4,349	487,683
PTH	Physical Therapy	9.5%	14.4%	12,074,889	9,822,961	21,897,850	12,824,985	10,378,139	23,203,124	750,096	555,178	1,305,274
OTH	Occupational Therapy	13.1%	18.9%	7,874,851	2,864,821	10,739,672	8,397,288	3,038,381	11,435,669	522,437	173,560	695,997
STH	Speech Therapy	12.5%	18.5%	2,673,368	1,999,158	4,672,526	2,841,253	2,112,918	4,954,170	167,885	113,759	281,644
OA	Organ Acquisition	4.7%	5.5%	1,162,432	111,250	1,273,682	1,212,848	156,199	1,369,047	50,415	44,949	95,364
LEU	Leukopheresis (LEU)	14.6%	5.9%	2,496,555	463,129	2,959,684	2,667,810	494,892	3,162,702	171,255	31,763	203,017
HYP	Hyperbaric Chamber	25.6%	8.3%	94,190	794,601	888,791	99,959	846,482	946,441	5,768	51,882	57,650
AUD	Audiology	29.1%	23.0%	150,486	475,913	626,399	156,769	511,396	668,165	6,283	35,484	41,767
MRI	MRI Scanner	13.5%	8.5%	9,235,434	5,418,500	14,653,934	9,705,507	5,737,734	15,443,241	470,073	319,234	789,307
AMR	Ambulance	12.5%	40.0%	149,411	16,516	165,928	149,812	16,523	166,335	400	6	407
TMT	TUMT	0.0%	0.0%	-	-	-	-	-	-	-	-	-
ADM	Admissions	20.9%	28.1%	25,258,665	250	25,258,915	22,312,051	220	22,312,271	(2,946,614)	(30)	(2,946,643)
MSS	Med./Surg. Supplies	9.2%	8.6%	104,649,673	48,291,548	152,941,222	110,921,347	51,137,242	162,058,589	6,271,673	2,845,693	9,117,367
CDS	Drugs	17.0%	8.5%	117,577,251	51,120,718	168,697,969	124,480,471	54,003,711	178,484,181	6,903,220	2,882,992	9,786,212
REC	Recreational Therapy	13.3%	0.0%	219	-	219	219	-	219	-	-	-
TNA	TUNA	0.0%	0.0%	-	-	-	-	-	-	-	-	-
ORC	Operating Room Clinic	14.3%	9.4%	331,935	3,971,791	4,303,727	353,417	4,202,946	4,556,364	21,482	231,155	252,637
IRC	Interventional Radiolo	11.9%	5.8%	20,162,247	8,075,457	28,237,703	21,429,831	8,574,556	30,004,387	1,267,584	499,100	1,766,684
OBV	Observation	15.5%	17.3%	2,256,109	20,056,523	22,312,632	2,389,325	21,105,213	23,494,538	133,216	1,048,690	1,181,906
Totals				$1,686,086,436	$807,594,447	$2,493,680,883	$1,615,623,798	$848,880,305	$2,464,504,104	($70,462,637)	$41,285,858	($29,176,779)

Medicaid Total Dollar Savings:	($29,176,779)
Medicaid State Only Savings:	($13,713,086)

Note: Calculation does not include Kernan; No 1/1/12 rate order has been issued for McCready so the 7/1/11 rate order was used.

Maryland Hospital Community Benefits Report
FY 2011

June 6, 2012

Health Services Cost Review Commission
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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 2011. Individual hospital community benefit reports are available at the Commission's offices. Individual community benefit report data spreadsheets and reports will be available on the Commission's website in June 2012.

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 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 will be due by the end of a hospital's fiscal year 2013 (by June 30, 2013 for a June 30 YE hospital). 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. This information will be reported on Schedule H of the IRS 990 forms.

The Maryland CBR process was enacted by the Maryland General Assembly in 2001 (Chapter 178 of the 2001 Laws of Maryland, and codified under Health-General Article §19-303 of the Maryland Annotated Code). The Maryland data reporting spreadsheet and instructions in their inception drew heavily on the experience of the Voluntary Hospitals of America ("VHA"), a nationwide network of community owned health care systems, which possessed over ten years of voluntary hospital community benefit reporting experience across many states. Since 2003, the Commission has worked with the Maryland Hospital Association and interested hospitals, local health departments, and health policy organizations and associations on the details, format, and updates to the community benefit report. The CBR process offers an opportunity for each Maryland acute care hospital to critically review and report its activities designed to benefit the community it serves. The first CBR (reporting FY 2004 experiences) was released in July 2005.

The Fiscal Year 2011 report represents the HSCRC's eighth 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 45 acute, not-for-profit hospitals as a result of the tax exemptions they receive. [1]

CBR – 2011 Highlights

The reporting period for this Community Benefit Report is July 1, 2010 – June 30, 2011. Hospitals submitted their individual community benefit reports to the HSCRC by December 15,

[1] Southern Maryland Hospital, the only for-profit hospital in Maryland, is not required to submit a community benefits report under the law. However, they have continued to submit a community benefit report to the HSCRC.

2011 using audited financial statements as the source for calculating costs in each of the care categories. New to the FY 2011 reporting categories is Unreimbursed Medicaid Cost. Hospitals and payers were asked to share a portion of the cost of Maryland's Medicaid budget shortfall in FY 2011. Pursuant to the request by Maryland hospitals, the CB Advisory group agreed that hospitals were to consider the unreimbursed portion as community benefit expenditure. A table was added to the data collection tool that asked hospitals to report the total amount of the assessment under direct costs, and the amount paid by payers as offsetting revenue. The resulting calculation of net community benefit shows the actual amount of a hospital's portion of the deficit assessment.

As shown in Table I below, Maryland hospitals provided approximately $1.2 billion dollars in total community benefit activities in FY 2011 (up from $1 billion in FY 2010). This total is comprised of $33.8 million in Unreimbursed Medicaid Cost, over $82.9 million in Community Health Services, more than $348 million in Health Professions Education, $285 million in Mission Driven Health Care Services, $6.2 million in Research activities, just over $14 million in Financial Contributions, $28.2 million in Community Building Activities, over $6.4 million in Community Benefit Operations, and over $2.6 million in Foundation Funded Community Benefits.[2] Overall, Maryland hospitals reported providing just over $395 million in Charity Care.

Table I – Total Community Benefit

Community Benefit Category	Number of Staff Hours	Number of Encounters	Total Community Benefit
Unreimbursed Medicaid Cost			$33,873,757
Community Health Services	860,437	11,104,243	$82,954,254
Health Professions Education	6,048,080	279,316	$348,084,984
Mission Driven Health Services	1,896,145	977,079	$285,336,633
Research	72,040	23,333	$6,253,037
Financial Contributions	45,515	1,156,124	$14,042,639

[2] 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.

Community Building	156,751	528,870	$28,276,370
Community Benefit Operations	57,255	38,438	$6,410,085
Foundation	57333	22,183	$2,691,274
Charity Care	n/a	n/a	$395,094,660
Total	9,193,556	14,129,585	$1,203,017,693

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

Utilizing the data reported, Attachment II, of the FY 2011 CB Analysis, compares hospitals on the total amount of community benefits reported, the amount of community benefits that are recovered though HSCRC approved rates (charity care, direct medical education, and nurse support), and the number of staff dedicated to community benefit operations. On average, in FY 2011, 1,245 staff hours were dedicated to CB Operations. This is up by 406 hours from last year's average of 839. Eleven hospitals continue to report zero hours dedicated to CB Operations versus thirteen hospitals in FY 2010. The HSCRC continues to encourage hospitals to incorporate CB Operations into their overall strategic planning.

The total amount of community benefit dollars as a percentage of total operating expenses ranges from 2.14% to 18.81% with the average amount being 9.23%. This has increased from FY 2010's average of 7.71%. There are sixteen hospitals that report providing benefits in excess of 10% of their operating expenses, as compared to eight in FY 2010. Only two hospitals report spending less than 3% of their operating expenses on community benefit compared to four hospitals last year.

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 <u>not</u> include revenue provided in rates as offsetting revenue on the CBR worksheet. Attachments III, IV, and V detail 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 2011.

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 shown in Attachment III, just under $375 million in charity care was provided through Maryland hospital rates in FY 2011 that was funded by all payers. When offset against the hospital reported amount of $395 million in charity care, the net amount provided by hospitals is just over $20 million.

Also as noted, another social cost funded in Maryland's rate-setting system is 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 2011, these DME costs totaled $235.3 million. For further information about DME costs by specific hospitals, please see Attachment IV.

The Commission's Nurse Support Program I (NSPI) is aimed at addressing the short and long-term nursing shortage impacting Maryland hospitals. In FY 2011, over $12.3 million was provided in hospital rate adjustments for NSPI. For further information about funding provided to specific hospitals, please see Attachment V.

When these costs are offset, the net community benefit provided by Maryland hospitals in FY 2011 was $ 580.4 million, or 4.45% of the total hospital operating expenses. This is down slightly from the $613.5 million in net benefits provided in FY 2010, which totaled approximately 4.85% of hospitals' operating expenses. Please see the chart in Attachment II for more detail.

In FY 2011, hospitals were again asked to answer 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.

The evaluation tool, resulting from the HSCRC advisory group was used to evaluate hospitals' Community Benefit Narrative Reports. The group of evaluators consisted of three people, a member of HSCRC staff, a representative of the Maryland Hospital Association, and public health official from the Department of Health and Mental Hygiene (DHMH).

Changes to the FY 2012 Reporting Requirements

Based on input from the CB advisory group, the HSCRC is making only slight changes to the FY 2012 Community Benefit Reporting Guidelines and Standard Definitions as well as to the Community Benefits Narrative Reporting Instructions and related Evaluation. The following changes were made to the Reporting Guidelines:

- P. 4 - Hospitals are reminded that the report should be limited to regulated hospital services that are reported on the IRS 990 schedule H, and should not include unregulated entities.
- P. 18 - Hospitals are reminded that reported **Cash and In Kind Contributions** are restricted to funds allocated to Community Benefits, as reported on the IRS 990 Schedule H.

Changes to the Community Benefit Narrative Reporting Instructions include:

- **Section II. Community Health Needs Assessment** revised to more clearly reflect the difference between the federally required 'CHNA' and the community needs assessment as described in Health General §19-303(a)(4).
- **Section III. Community Benefit Administration** revised a question regarding hospital strategic planning.
- **Section IV. Hospital Community Benefit Program and Initiatives** revised to ask hospitals to include process and outcome measures for their key initiatives listed and described in Table III. A column was added to collect hospitals' current fiscal year costs for initiatives listed in Table III.
- **Collection of a Description of the Hospital's efforts to track and reduce health disparities in the community that it serves** – pursuant to Senate Bill 234, this information will be required in the FY2013 report. The CB advisory group has recommended the Narrative Reporting Instructions be revised to reflect a data collection mechanism on a non-mandatory basis in the FY 2012 report. Once input is received from various DHMH/HSCRC workgroups designed to discuss disparities and hospital reporting of such data, the CB Advisory Group will meet to determine the best format and content for a description of hospitals' disparity initiative.

Changes to the Narrative Evaluation Criteria include:

- **Section III. Community Benefit Administration** removing question 1.iv. "Other". This question was found to be unclear and caused an unnecessary loss of points to hospitals that didn't answer the question.
- **Section V. Physicians –** removed point value from question 2.

As in previous years, the HSCRC will continue in its efforts to evaluate the reporting process, and make changes where necessary to ensure that hospitals are accurately and appropriately reporting on their programs and initiatives and that are specifically designed to meet the growing health needs of the communities they serve.

Attachment I – FY 2011 CB Aggregate Data

FY 2011 Aggregate Data

	UNREIMBURSED MEDICAID COST	# OF STAFF HOURS	# OF ENCOUNTERS	DIRECT COST($)	INDIRECT COST($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
T00	**Medicaid Costs**							
T99	Medicaid Assessments	0	0	**$129,529,100**	**$0**	**$95,655,343**	**$33,873,757**	**$33,873,757**

	COMMUNITY BENEFIT ACTIVITES	# OF STAFF HOURS	# OF ENCOUNTERS	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
A00.	**COMMUNITY HEALTH SERVICES**							
A10	Community Health Education	**223,800**	**10,244,116**	**$17,452,966**	**$9,651,407**	**$2,177,240**	**$24,927,133**	**$15,275,726**
A11	Support Groups	**22,404**	**43,969**	**$997,236**	**$555,638**	**$39,974**	**$1,512,900**	**$957,262**
A12	Self-Help	**41,687**	**180,393**	**$2,391,402**	**$1,217,633**	**$988,203**	**$2,620,832**	**$1,403,199**
A20	Community-Based Clinical Services	**313,219**	**158,695**	**$14,926,963**	**$3,404,320**	**$496,371**	**$17,834,911**	**$14,430,592**
A21	Screenings	**32,033**	**72,665**	**$2,000,260**	**$1,020,215**	**$323,031**	**$2,697,444**	**$1,677,229**
A22	One-Time/Occasionally Held Clinics	**5,937**	**68,020**	**$688,735**	**$371,726**	**$172,761**	**$887,700**	**$515,974**
A23	Free Clinics	**1,441**	**4,263**	**$407,741**	**$241,788**	**$69,571**	**$579,958**	**$338,170**
A24	Mobile Units	**20,702**	**18,389**	**$1,137,598**	**$496,535**	**$514,816**	**$1,119,317**	**$622,782**
A30	Health Care Support Services	**159,116**	**222,389**	**$16,391,473**	**$8,296,440**	**$577,487**	**$24,110,426**	**$15,813,986**
A40	Blood Drives	**19,622**	**64,830**	**$1,561,404**	**$875,168**	**$114,859**	**$2,321,714**	**$1,446,545**
A41	Interpreter Services	**500**	**3,957**	**$104,830**	**$65,842**	**$0**	**$170,672**	**$104,830**
A42	Medicaid Enrollment	**18,043**	**22,185**	**$2,304,833**	**$1,669,868**	**$0**	**$3,974,701**	**$2,304,833**
A43	SAFE Program	**1,934**	**372**	**$130,548**	**$65,998**	**$0**	**$196,546**	**$130,548**
A44		**0**	**0**	**$0**	**$0**	**$0**	**$0**	**$0**
A99	**Total Community Health Services**	**860,437**	**11,104,243**	**$60,495,989**	**$27,932,579**	**$5,474,313**	**$82,954,254**	**$55,021,676**

		# OF STAFF HOURS	# OF ENCOUNTERS	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
B.	**HEALTH PROFESSIONS EDUCATION**							
B1	**Physicians/Medical Students**	**5,295,469**	**19,653**	**$246,446,091**	**$61,701,349**	**$0**	**$308,147,440**	**$246,446,091**
B2	Nurses/Nursing Students	**385,851**	**120,200**	**$17,687,689**	**$4,603,529**	**$66,480**	**$22,224,738**	**$17,621,209**
B3	Other Health Professionals	**234,997**	**103,939**	**$8,716,554**	**$1,684,505**	**$94,567**	**$10,306,492**	**$8,621,987**
B4	Scholarships/Funding for Professional Educatior	**19,534**	**713**	**$2,814,213**	**$230,380**	**$59,475**	**$2,985,118**	**$2,754,738**
B5		**95,806**	**33,762**	**$3,167,815**	**$274,908**	**$2,696**	**$3,440,027**	**$3,165,119**
B6		**14,400**	**170**	**$653,379**	**$193,612**	**$0**	**$846,991**	**$653,379**
B7		**2,023**	**880**	**$170,988**	**$28,532**	**$65,342**	**$134,178**	**$105,645**
B8		**0**	**0**	**$0**	**$0**	**$0**	**$0**	**$0**
B99	**Totals**	**6,048,080**	**279,316**	**$279,656,730**	**$68,716,814**	**$288,560**	**$348,084,984**	**$279,368,170**

		# OF STAFF HOURS	# OF ENCOUNTERS	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
	MISSION DRIVEN HEALTH SERVICES							
C.	**Totals**	**1,896,145**	**977,079**	**$350,623,897**	**$83,703,435**	**$148,990,700**	**$285,336,633**	**$201,633,197**

		# OF STAFF HOURS	# OF ENCOUNTERS	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
D.	**RESEARCH**							
D1	**Clinical Research**	**59,541**	**23,280**	**$5,840,823**	**$1,353,415**	**$1,879,099**	**$5,315,139**	**$3,961,724**
D2	**Community Health Research**	**19**	**54**	**$139,277**	**$12,617**	**$0**	**$151,894**	**$139,277**
D3	**Other**	**6,240**	**0**	**$182,065**	**$109,148**	**$0**	**$291,213**	**$182,065**
D4		**6,240**	**0**	**$316,161**	**$178,631**	**$0**	**$494,792**	**$316,161**
D5		**0**	**0**	**$0**	**$0**	**$0**	**$0**	**$0**
D99	**Totals**	**72,040**	**23,333**	**$6,478,326**	**$1,653,810**	**$1,879,099**	**$6,253,037**	**$4,599,227**

FY 2011 Aggregate Data

E.	Financial Contributions	# OF STAFF HOURS	# OF ENCOUNTERS	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
E1	Cash Donations	2,138	756,976	$7,967,278	$80,229	$0	$8,047,507	$7,967,278
E2	Grants	312	0	$452,989	$6,347	$287,649	$171,688	$165,340
E3	In-Kind Donations	42,997	398,208	$4,679,198	$873,067	$199,219	$5,353,048	$4,479,981
E4	Cost of Fund Raising for Community Prograr	69	940	$399,834	$74,362	$3,800	$470,396	$396,034
E99	Totals	45,515	1,156,124	$13,499,299	$1,034,006	$490,668	$14,042,639	$13,008,633

F.	COMMUNITY BUILDING ACTIVITIES	# OF STAFF HOURS	# OF ENCOUNTERS	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
F1	Physical Improvements/Housing	8,162	310,815	$3,271,275	$335,679	$2,371,554	$1,235,400	$899,721
F2	Economic Development	18,928	8,465	$1,519,195	$841,628	$491,269	$1,869,553	$1,027,926
F3	Support System Enhancements	32,095	27,790	$2,205,634	$1,274,061	$163,736	$3,315,958	$2,041,898
F4	Environmental Improvements	9,695	162	$1,468,062	$155,956	$0	$1,624,017	$1,468,062
F5	Leadership Development/Training for Commu	5,348	4,261	$300,890	$180,445	$0	$481,335	$300,890
F6	Coalition Building	6,941	7,067	$661,940	$365,834	$150	$1,027,624	$661,790
F7	Community Health Improvement Advocacy	6,687	56,700	$5,396,895	$610,673	$12,000	$5,995,567	$5,384,895
F8	Workforce Enhancement	31,825	14,518	$4,045,775	$2,186,540	$150,864	$6,081,452	$3,894,911
F9	Other	35,705	99,091	$2,224,859	$1,020,462	$27,115	$3,218,206	$2,197,744
F10	Other	1,364	1	$67,658	$55,531	$1,073	$122,116	$66,585
F11	Sales Tax, Property Tax, Income Taxes	0	0	$3,305,140	$0	$0	$3,305,140	$3,305,140
F99	Totals	156,751	528,870	$24,467,322	$7,026,809	$3,217,761	$28,276,370	$21,249,561

G.	COMMUNITY BENEFIT OPERATIONS	# OF STAFF HOURS	# OF ENCOUNTERS	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
G1	Dedicated Staff	51,433	30,051	$2,689,903	$1,286,557	$15,193	$3,961,267	$2,674,710
G2	Community health/health assets assessments	3,314	491	$198,959	$96,748	$3,433	$292,274	$195,526
G3	Other Resources	221	85	$1,099,952	$499,305	$0	$1,599,257	$1,099,952
G4		2,287	7,812	$353,638	$203,649	$0	$557,287	$353,638
G5		0	0	$0	$0	$0	$0	$0
G99	Totals	57,255	38,438	$4,342,452	$2,086,259	$18,626	$6,410,085	$4,323,826

H.	CHARITY CARE (report total only)
	$395,094,660

FY 2011 Aggregate Data

		# OF STAFF HOURS	# OF ENCOUNTERS	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
	FOUNDATION COMMUNITY BENEFIT							
J.	Community Services	12,971	3,540	$828,762	$317,308	$14,968	$1,131,102	$813,794
J1	Community Building	44,362	18,643	$1,877,871	$78,665	$396,364	$1,560,172	$1,481,507
J2	Other	0	0	$0	$0	$0	$0	$0
J3		0	0	$0	$0	$0	$0	$0
		0	0	$0	$0	$0	$0	$0
	Totals	57,333	22,183	$2,706,633	$395,973	$411,332	$2,691,274	$2,295,301

		# OF STAFF HOURS	# OF ENCOUNTERS	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit W/Indirect Cost	Net Community Benefit W/O Indirect Cost
K	TOTAL HOSPITAL COMMUNITY BENEFIT							
A	Community Health Services	860,437	11,104,243	$60,495,989	$27,932,579	$5,474,313	$82,954,254	$55,021,676
B	Health Professions Education	6,048,080	279,316	$279,656,730	$68,716,814	$288,560	$348,084,984	$279,368,170
C	Mission Driven Health Care Services	1,896,145	977,079	$350,623,897	$83,703,435	$148,990,700	$285,336,633	$201,633,197
D	Research	72,040	23,333	$6,478,326	$1,653,810	$1,879,099	$6,253,037	$4,599,227
E	Financial Contributions	45,515	1,156,124	$13,499,299	$1,034,006	$490,668	$14,042,639	$13,008,633
F	Community Building Activities	156,751	528,870	$24,467,322	$7,026,809	$3,217,761	$28,276,370	$21,249,561
G	Community Benefit Operations	57,255	38,438	$4,342,452	$2,086,259	$18,626	$6,410,085	$4,323,826
H	Charity Care	0	0	$0	$0	$0	$395,094,660	$395,094,660
J	Foundation Funded Community Benefit	57,333	22,183	$2,706,633	$395,973	$411,332	$2,691,274	$2,295,301
T99	Medicaid Assessments	0	0	$129,529,100	$0	$95,655,343	$33,873,757	$33,873,757
K99	TOTAL HOSPITAL COMMUNITY BENEFIT	9,193,556	14,129,585	$871,799,748	$192,549,685	$256,426,402	$1,203,017,693	$1,010,468,008
	TOTAL OPERATING EXPENSE							
	% OF OPERATING EXPENSES W/IC							
	% OF OPERATING EXPENSES W/O IC							

Attachment II – FY 2011 CB Analysis

Hospid	Hospital Name	Employees	Total Staff Hours CB Operations	Total Hospital Operating Expense	Total Community Benefit	Total CB as % of Total Operating Expense	FY 2011 Amount in Rates for Charity Care, DME, and NSPI	Total Net CB minus Chairty Care, DME, NSPI in Rates	Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care	Point Totals for Sufficiency of Narrative Answers	
7	St. Joseph	2225	0	$330,327,712	$7,065,084	2.14%	$4,709,744	$2,355,340	0.71%	$4,369,778	113	
60	Fort Washington	477	0	$40,954,995	$1,087,898	2.66%	$650,064	$437,834	1.07%	$602,822	51	
51	Doctors	1438	85	$194,523,558	$6,370,958	3.28%	$2,317,420	$4,053,538	2.08%	$2,128,738	50	
44	GBMC	3000	0	$392,667,399	$17,888,069	4.56%	$10,904,712	$6,983,357	1.78%	$4,868,278	81	
35	Civista	783	4,998	$102,090,948	$4,799,387	4.70%	$1,866,221	$2,933,166	2.87%	$1,762,608	142	
43	Baltimore Washington	2699	80	$319,612,000	$15,618,868	4.89%	$10,593,562	$5,025,306	1.57%	$7,907,000	134	
23	Anne Arundel	3630	872	$439,610,000	$23,354,162	5.31%	$6,192,407	$17,161,755	3.90%	$5,896,911	141	
19	Peninsula	2662	185	$366,862,000	$19,541,108	5.33%	$10,158,000	$9,383,108	2.56%	$10,603,500	120	
32	Union Cecil County	1023	1,200	$135,590,000	$7,444,489	5.49%	$2,523,850	$4,920,639	3.63%	$2,415,495	133	
49	UCH-Upper Chesapeake	1795	7	$194,088,000	$11,352,352	5.85%	$2,675,199	$8,677,153	4.47%	$3,679,633	132	
37	Shore Health - Easton	1309	0	$140,221,608	$8,779,472	6.26%	$4,398,332	$4,381,140	3.12%	$4,238,270	132	
5	Frederick Memorial	2160	0	$332,418,000	$21,123,068	6.35%	$8,063,374	$13,059,694	3.93%	$7,810,600	108	
54	Southern Maryland	1808	0	$227,132,278	$15,359,445	6.76%	$3,240,887	$12,118,558	5.34%	$3,102,367	N/A	
2004	Good Samaritan	2384	1,981	$300,220,500	$22,094,477	7.36%	$11,841,241	$10,253,236	3.42%	$6,547,400	129	
38	Maryland General	1321	862	$178,038,000	$13,282,293	7.46%	$11,966,172	$1,316,121	0.74%	$8,173,000	127	
22	Suburban	1400	2,100	$241,360,000	$18,280,913	7.57%	$4,122,943	$14,157,970	5.87%	$4,007,000	149	
45	McCready	275	80	$17,313,509	$1,315,329	7.60%	$913,419	$401,910	2.32%	$987,906	118	
18	Montgomery General	1356	147	$133,009,700	$10,224,000	7.69%	$6,102,619	$4,121,381	3.10%	$5,962,000	107	
48	Howard County	1656	280	$226,186,000	$18,124,397	8.01%	$4,853,624	$13,270,773	5.87%	$4,704,963	128	
28	St. Mary's	1109	1,420	$112,047,400	$9,007,302	8.04%	$3,511,600	$5,495,702	4.90%	$3,387,500	149	
40	Northwest	1623	0	$204,008,000	$16,518,045	8.10%	$3,904,014	$12,614,031	6.18%	$3,692,000	115	
15	Franklin Square	3451	4,252	$410,262,600	$34,040,088	8.30%	$11,294,763	$22,745,325	5.54%	$10,808,600	147	
11	St. Agnes	2599	0	$380,659,763	$31,602,911	8.30%	$21,514,185	$10,088,726	2.65%	$17,920,497	120	
1	Meritus Medical Center	2095*	282	$270,510,801	$23,160,801	8.56%	$9,889,492	$13,271,309	4.91%	$11,515,068	126	
17	Garrett County	315	160	$35,606,008	$3,190,531	8.96%	$2,652,174	$538,357	1.51%	$2,765,783	105	
12	Sinai	4564	2,810	$651,313,000	$59,913,433	9.20%	$26,316,773	$33,596,660	5.16%	$10,981,000	121	
6	UCH-Harford	777	3	$88,883,000	$8,434,988	9.49%	$1,472,635	$6,962,353	7.83%	$2,546,397	132	
10	Shore Health -Dorchester	630	0	$41,944,947	$3,986,114	9.50%	$2,089,434	$1,896,680	4.52%	$2,036,690	132	
61	Atlantic General	811	442	$88,062,865	$8,451,666	9.60%	$1,396,184	$7,055,482	8.01%	$1,475,240	128	
9	Johns Hopkins	8997	7,803	$1,648,599,000	$164,609,122	9.98%	$116,734,661	$47,874,461	2.90%	$29,978,000	145	
24	Union Memorial	2528*	180	$384,090,500	$38,479,303	10.02%	$22,519,331	$15,959,972	4.16%	$11,807,500	137	
5050	Shady Grove	2091*	1,812	$269,589,155	$27,093,790	10.05%	$9,320,629	$17,773,161	6.59%	$10,323,710	128	
2001	Kernan	675	400	$90,594,000	$9,126,861	10.07%	$5,307,961	$3,818,900	4.22%	$1,730,000	129	
4	Holy Cross	3212	6,501	$389,986,549	$39,534,517	10.14%	$19,642,463	$19,892,054	5.10%	$19,235,553	149	
29	JH Bayview	3519	511	$504,690,000	$52,067,111	10.32%	$40,391,695	$11,675,416	2.31%	$21,235,606	139	
34	Harbor Hospital	1381	98	$183,840,500	$20,754,564	11.29%	$11,347,704	$9,406,860	5.12%	$7,036,300	149	
27	Western MD Regional	2192	311	$293,906,377	$34,203,083	11.64%	$12,465,742	$21,737,341	7.40%	$12,443,989	148	
8	Mercy	3146	158	$386,361,000	$45,419,866	11.76%	$16,998,322	$28,421,544	7.36%	$12,057,000	96	
33	Carroll Hospital	1750	5,011	$188,182,000	$22,159,392	11.78%	$3,208,054	$18,951,338	10.07%	$3,011,868	143	
39	Calvert Memorial	1146	280	$115,707,400	$13,857,990	11.98%	$4,282,517	$9,575,473	8.28%	$4,317,996	116	
2	University of Maryland	5937*	1,381	$1,249,077,000	$167,896,743	13.44%	$101,187,830	$66,708,913	5.34%	$49,770,761	139	
16	Washington Adventist	1580*	2,638	$211,836,413	$31,432,929	14.84%	$10,540,537	$20,892,392	9.86%	$9,117,152	126	
30	Chester River	471	0	$55,032,000	$8,914,772	16.20%	$4,376,414	$4,538,358	8.25%	$4,509,800	139	
55	Laurel Regional	524	0	$94,179,100	$16,135,485	17.13%	$6,550,140	$9,585,345	10.18%	$6,457,000	67	
13	Bon Secours	786	7,875	$135,427,187	$24,215,836	17.88%	$19,502,893	$4,712,943	3.48%	$12,562,380	119	
3	Prince George's	1893	51	$242,965,900	$45,704,680	18.81%	$26,090,275	$19,614,405	8.07%	$22,603,000	69	
	Totals	**78,972**	**57,256**	**$13,039,588,672**	**$1,203,017,692**	**9.23%**	**$622,602,213**	**$580,415,478**	**4.45%**	**$395,094,659**		
											128	**median**
	Averages	**1,926**	**1,245**								**122 out of a total of 149**	**average**
		*** The hospital did not provide the number of employees in its FY 2011 CB report,**										
		therefore the number reported is from the FY 2010 report.										

Attachment III – FY 2011 Charity Care Funding

Hospital Name	Charity Care Amount in Rates
Anne Arundel General Hospital	$5,799,900
Atlantic General Hospital	$1,319,700
Baltimore Washington Medical Center	$9,945,700
Bon Secours Hospital	$11,360,350
Calvert Memorial Hospital	$4,171,100
Carroll County General Hospital	$3,011,900
Chester River Hospital Center	$4,315,500
Civista Medical Center	$1,762,600
Doctors Community Hospital	$2,128,700
Fort Washington Medical Center	$602,822
Franklin Square Hospital	$10,808,600
Frederick Memorial Hospital	$7,810,600
Garrett County Memorial Hospital	$2,617,500
GBMC	$4,801,800
Good Samaritan Hospital	$6,482,300
Harbor Hospital Center	$7,036,300
Holy Cross Hospital of Silver Spring	$16,579,500
Howard County General Hospital	$4,705,000
JH Bayview Med. Center	$21,020,600
Johns Hopkins Hospital	$29,978,300
Kernan	$1,730,000
Laurel Regional Hospital	$6,458,500
Maryland General Hospital	$8,173,000
McCready Foundation, Inc.	$896,600
Mercy Medical Center, Inc.	$12,057,100
Montgomery General Hospital	$5,962,000
Northwest Hospital Center, Inc.	$3,692,300
Peninsula Regional Medical Center	$10,108,000
Prince Georges Hospital	$22,602,800
Shady Grove Adventist Hospital	$8,989,913
Shore Health - Easton	$4,238,300
Shore Health-Dorchester General Hospital	$2,036,700
Sinai Hospital	$10,981,200
Southern Maryland Hospital	$3,016,056
St. Agnes Hospital	$14,578,700
St. Joseph Hospital	$4,310,900
St. Mary's Hospital	$3,387,500
Suburban Hospital	$3,894,700
UCH - Harford Memorial Hospital	$1,376,400
UCH - Upper Chesapeake Medical Center	$2,478,400
Union Hospital of Cecil County	$2,407,100
Union Memorial Hospital	$11,798,900
University of Maryland	$41,235,800
Washington Adventist Hospital	$10,256,290
Meritus Medical Center	$9,658,400
Western Maryland Regional Medical Center	$12,314,300
Total	$374,898,631

Attachment IV - FY 2011 DME Funding

Hospital Name	DME Amount in Rates
Anne Arundel	0
Atlantic General	0
Baltimore Washington	$338,521
Bon Secours	$8,020,399
Calvert Memorial	0
Carroll Hospital	0
Chester River	0
Civista	0
Doctors	0
Fort Washington	0
Franklin Square	$71,175
Frederick Memorial	0
Garrett County	0
GBMC	$5,709,750
Good Samaritan	$5,072,645
Harbor Hospital	$4,201,169
Holy Cross	$2,668,497
Howard County	0
JH Bayview	$18,857,600
Johns Hopkins	$85,136,081
Kernan	$3,480,668
Laurel Regional	0
Maryland General	$3,612,544
McCready	0
Mercy	$4,559,222
Meritus Medical Center	0
Montgomery General	0
Northwest	0
Peninsula	0
Prince George's	$3,237,135
Shady Grove	0
Shore Health - Easton	0
Shore Health -Dorchester	0
Sinai	$14,708,295
Southern Maryland	0
St Agnes	$6,601,930
St Joseph	0
St Mary's	0
Suburban	0
UCH-Harford	0
UCH-Upper Chesapeake	0
Union Cecil County	0
Union Memorial	$10,306,584
University of Maryland	$58,804,210
Washington Adventist	0
Western Maryland Regional Medical Center	0
Total	$235,386,426

Attachment V - FY 2011 Nurse Support I Funding

Hospital Name	NSP I Amount in Rates
Anne Arundel	$392,507
Atlantic General	$76,484
Baltimore Washington	$309,341
Bon Secours	$122,144
Calvert Memorial	$111,417
Carroll Hospital	$196,154
Chester River	$60,914
Civista	$103,621
Doctors	$188,720
Fort Washington	$47,242
Franklin Square	$414,988
Frederick Memorial	$252,774
Garrett County	$34,674
GBMC	$393,162
Good Samaritan	$286,296
Harbor Hospital	$110,235
Holy Cross	$394,466
Howard County	$148,624
JH Bayview	$513,495
Johns Hopkins	$1,620,280
Kernan	$97,293
Laurel Regional	$91,640
Maryland General	$180,628
McCready	$16,819
Mercy	$382,000
Meritus Medical Center	$231,092
Montgomery General	$140,619
Northwest	$211,714
Peninsula	$50,000
Prince George's	$250,340
Shady Grove	$330,716
Shore Health - Easton	$160,032
Shore Health -Dorchester	$52,734
Sinai	$627,278
Southern Maryland	$224,831
St Agnes	$333,555
St Joseph	$398,844
St Mary's	$124,100
Suburban	$228,243
UCH-Harford	$96,235
UCH-Upper Chesapeake	$196,799
Union Cecil County	$116,750
Union Memorial	$413,847
University of Maryland	$1,147,820
Washington Adventist	$284,247
Western Maryland Regional Medical Center	$151,442
Total	$12,317,156

FY2012 Community Benefit Collection/Evaluation Tools

June 6, 2012

Revised
June 6, 2012

Community Benefit Reporting Guidelines and Standard Definitions

FY 2012

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Acknowledgements

This document draws heavily on the collaboration among VHA Inc., the Catholic Health Association of the United States, and Lyon Software, which worked to create standardized community benefit categories, definitions, and reporting guidelines in an effort to achieve a national standardized approach for not-for-profit health care organizations. The HSCRC would like to express its appreciation to these organizations for providing their permission to use this document for Maryland's Community Benefit Reporting Initiative.

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Complete the Community Benefit Collection Tool provided by the HSCRC using the following guidelines;

Financial Accounting
In terms of financial accounting practices, hospitals should use audited financial statements as the source. Hospitals with a fiscal year that coincides or closely coincides with the HSCRC's required Community Benefit reporting period of July 1 to June 30 should report Community Benefit data using the most recent audited financial statements as the source.

Hospitals whose fiscal year is calendar-year based should also collect community benefit information for the reporting period of July 1 through June 30. Since a calendar year hospital's audited financial statements will not be completed by January 1 of the following year, however, the Commission understands that all information contained within the Community Benefit Report may not directly correlate to final audited figures. A hospital should make clear in its Community Benefit Report submission, therefore, the types of financial data used and time periods covered. Every effort should be made to have these reported figures directly tie to the hospital's financial statements.

The data included in this report should be limited to Regulated Hospital Services that are reported on the IRS 990 schedule H, and should not include unregulated entities.

Offsetting Revenue
Finally, for completion of the statewide Community Benefit Report for distribution to the public, the HSCRC will include hospital-specific information regarding the amount of revenue provided to the hospital in rates for the appropriate fiscal year for Graduate Medical Education, Nurse Support Programs, and Uncompensated Care. Therefore, offsetting revenue provided in the form of HSCRC – approved rates to the hospital should not be reported in the "offsetting revenue" column. Additionally, for the purposes if this report, offsetting revenue shall be considered as revenue from the activity during the year that offsets the total community benefit expense of that activity, it includes any revenue generated by the activity or program, such as payment or reimbursement for services provided to program patients. It does not include restricted or unrestricted grants or contributions that the organization uses to provide the community benefit.

For more information please contact Steve Ports, Principal Deputy Director at sports@hscrc.state.md.us , or Amanda Greene, Audit and Compliance Division at agreene@hscrc.state.md.us, or at the Commission's offices at (410) 764-2605.

I. ACCOUNTING PRACTICES

A. Staff Hours & Number of Encounters

Hospitals should report the number of staff hours associated with and the number of encounters served by the reported community benefit activity (please note that a number of encounters is different than number of people served – one person could have several encounters).

B. Direct Costs

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

C. Indirect Costs

Indirect costs are costs not attributed to products and/or services that are included in the calculation of costs for community benefit. These could include, but are not limited to, salaries for human resources and finance departments, insurance, and overhead expenses.

Hospitals can currently calculate an indirect cost ratio from their HSCRC Annual Cost Report data. This can be calculated using Schedule M from the hospital's Annual Cost Report. To calculate:

1. Determine Indirect Expenses: Add the total of columns #3 (Patient Care Overhead), #4 (Other Overhead), #9 (Building and General Equipment CFA), and #10 (Departmental CFA).

2. Determine Direct Expenses: Add the total of columns #2 (Direct Expenses), #6 (Physician Support Expenses), and #7 (Resident Intern Expenses).

3. Divide Indirect Expenses by Direct Expenses. Please enter this number into Item I1. Please enter this number as a whole number, not as a percentage. The spreadsheet will convert the number into a percentage.

Rather than calculating a separate indirect cost per activity, the HSCRC inventory spreadsheet permits hospitals to calculate an indirect cost ratio calculated by the hospital and entered into Item I10 Indirect Cost Ratio, which can then be used to allocate indirect costs to the following community benefit categories: (A) Community Health Services; (F) Community Building Activities; and (G) Community Benefit Operations.

The HSCRC asks that hospitals examine its calculated indirect costs carefully, and to override the calculated indirect costs where the hospital believes the direct costs may, in part, reflect the total costs of the community benefit initiative. For the remaining categories, the indirect cost calculation will default to zero, and may be overridden if the hospital believes there are indirect costs involved with the initiative, but are not accurately represented in the direct costs.

D. Offsetting Revenue

Hospitals should report offsetting revenue as revenue from the activity during the year that offsets the total community benefit expense of that activity, it includes any revenue generated by the activity or program, such as payment or reimbursement for services provided to program patients. It does not include restricted or unrestricted grants or contributions that the organization uses to provide the community benefit.

E. Net Community Benefit

The Net Community Benefit column is a formula-driven cell that subtracts the sum of the hospital's reported direct and indirect costs from any reported offsetting revenue for each individual community benefit. Therefore, no number needs to be entered by the hospital in this column.

F. Accounting Practices and Calculating Costs

The hospital's financial statements most accurately reflect internal accounting practices for tracking community benefit programs and services, and negative margin departments are more easily identified and tracked. Verifying the calculations of a hospital's community benefit should also be done in conjunction with an organization's audited financial statements. Further, the

HSCRC plans to subject certain elements of the Community Benefit Report to future special audit and compliance checks.

II. COMMUNITY BENEFIT CATEGORIES AND REPORTING GUIDELINES

For the purpose of these reporting requirements, Maryland hospitals are the non-profit health care organization planning the community benefit.

A community benefit is a planned, organized, and measured approach, by a non-profit healthcare organization, to meeting identified community health needs within its service area. It most often requires collaboration with other non-profit and public organizations within the community in determining the health needs of its residents. Such planning relies on the use of objective data and information to determine community needs, and the impact of the organization's participation on those needs.

Community benefits respond to an identified community need, and meet the following criteria:

- Ultimately improve the health status and well being of specific populations in the organization's service area who are known to have difficulty accessing care and/or who have chronic needs;
- Generate a low or negative margin;
- Are not provided for marketing purposes; and/or
- The service or programs would likely be discontinued if the decision were made on a purely financial basis.

Maryland hospitals have raised many individual questions on whether a specific activity should be counted in the community benefits inventory. As a result, the Commission has looked to other organizations with expertise in community benefits that offer additional guidance on what may be considered an initiative or program appropriate for inclusion in a hospital's community benefits inventory.

The information provided below may be used as a reference guide in determining whether your organization's program fits the definition of a "Community Benefit."

The VHA, CHA, and Lyon Software collaborative document "Community Benefit Reporting Guidelines and Standard Definitions," states a community benefit is a planned, managed, organized, and measured approach to a health care organization's participation in meeting identified community health needs. It implies collaboration with a "community" to "benefit" its residents – particularly the poor, minorities, and other underserved groups – by improving health status and quality of life.

Community benefits respond to an identified community need and meet at least one of the following criteria:

- Generate a low or negative margin

- Respond to needs of special populations, such as minorities, frail elderly, poor persons with disabilities, the chronically mentally ill, and persons with AIDS
- Supply a service or programs that would likely be discontinued if the decision were made on a purely financial basis

To determine whether a program or cost is a community benefit, as opposed to a routine service or a marketing initiative, not-for-profit health care organizations can attempt to answer the following questions:

- Does the activity address an identified community need?
- Does the activity support an organization's community-based mission?
- Is the activity designed to improve health?
- Does the activity produce a measurable community benefit?
- Does the activity survive the "laugh" test (meaning it is not of a questionable nature that could jeopardize the credibility of the inventory)?
- Does an activity require subsidization (meaning it results in a net financial loss after applying grants and other supplemental revenue)?

These reporting guidelines can be used to assist hospitals in quantifying services for persons who are economically poor as well as services to the broader community. Community benefits are provided for both groups.

Persons who are economically poor or are medically indigent cannot afford health care because they have inadequate resources and/or are uninsured or underinsured. Criteria used to evaluate community benefit programs for this target population include:

- Most program users are economically poor
- Most program users cannot afford to pay for needed health care services
- Most program users are beneficiaries of Medicaid or state or local programs for the medically indigent
- The program is designed to reduce morbidity and mortality rates (e.g., low birth weight baby prevention) caused by or related to poverty
- The program is physically located in and apparently attracts most of it's participants from a site identified as poor or medically underserved via demographic data showing a higher-than-average poverty rate than the state as a whole
- Designation as a "medically underserved area" (MUA) or a "health manpower shortage area" (HMSA)

The term broader community refers to persons other than a "target population" who benefit from a health care organization's community services and programs.

<u>How to Count</u>

This document provides guidelines on how to count and quantify community benefits. To be included in a quantifiable inventory, services generally will:

- Result in a financial loss to the organization, requiring subsidization of some sort

- Best be quantified in terms of dollars spent, or number of encounters
- Not be of a questionable nature that jeopardizes the credibility of the inventory
- Have an explicit budget

In all categories, count negative contribution margin departments or services. Do not include bad debt.

T00. MEDICAID COSTS

In FY 2012, Maryland hospitals are required to provide a Deficit Assessment Fee to the Maryland Medicaid Program. A spreadsheet will be provided on the HSCRC website along with these instructions which will provide the total amount of the Deficit Assessment Fee, broken down between payer and hospital portions. The total assessment amount, (see column labeled, "Total Payments July 1, 2011 thru June 30, 2012"), for your hospital, should be reported in 'Direct Cost'. The payer portion, (see column labeled "Payer Portion") for your hospital, should be reported in 'Offsetting Revenues'. The resulting 'Net Community Benefit' will equal the hospital's portion of the assessment, (see column labeled "Hospital Portion" to verify the calculation).

A00. COMMUNITY HEALTH SERVICES

Community health services include activities carried out to improve community health. They extend beyond patient care activities and are usually subsidized by the health care organization. Community services do not generate inpatient or outpatient bills, although there may be a nominal patient fee and/or sliding scale fee. Forgiving inpatient and outpatient care bills to low income persons should be reported separately as charity care (See section H Charity Care).

Specific community health services to quantify include:

- Community health education
- Community-based clinical services, such as free clinics and screenings
- Support groups
- Health care support services, such as enrollment assistance in public programs, and transportation efforts
- Self-help programs, such as smoking-cessation and weight-loss programs
- Pastoral outreach programs
- Community-based chaplaincy programs
- Community spiritual care
- Social services programs for vulnerable populations in the community
- Other areas

As a reminder, Maryland law defines a community benefit as an activity that is "intended to address community needs and priorities primarily through disease prevention and improvement of health status."

A10. Community Health Education

Community health education includes lectures, presentations, and other programs and activities provided to groups, without providing clinical or diagnostic services. Community benefit in this area can include staff time, travel, materials, and indirect costs.

Count:

- Baby-sitting courses
- Writing an article on specific disease conditions or health issue as long as the purpose is not marketing
- Only the staff time used to write the article may be counted, the circulation number does not equal the number of encounters.
- This does not include scholarly publications such as journal articles or peer reviews.
-
- Caregiver training for persons caring for family members at home
- Community calendars and newsletters if the primary purpose is to educate the community about community health programs and free community events
- Consumer health library
- Education on specific disease conditions (diabetes, heart disease, etc.)
- Health fairs, career days
- Health promotion and wellness programs
- Health education lectures, workshops, or hospital tours by staff to community groups
- Pastoral outreach education programs
- Parish congregational programs
- Prenatal/childbirth classes serving at-risk populations
- Providing information through press releases and other modes to the media (radio, television, newspaper) to educate the public about health issues (wearing bike helmets, new treatments now available, health resources in the community, etc.)
- Public service announcements with health messages
- Radio call-in programs with health professionals
- School health education programs (report school-based programs on health care careers and workforce enhancement efforts in F8; report school-based health services for students in A2).
- Web-based consumer health information
- Work site health education programs

Do not count:

- Health education classes designed to increase market share (such as prenatal and childbirth programs for private patients)
- Community calendars and newsletters if the purpose is primarily a marketing tool
- Patient educational services understood as necessary for comprehensive patient care (e.g., diabetes education for patients)
- Prenatal and other educational programs for low income population that is reimbursed
- Health education sessions offered for a fee in which a profit is realized

- In-house pastoral education programs
- Volunteer time for parish and congregation-based and other services

A11. Support Groups
Support groups typically are established to address social, psychological or emotional issues related to specific diagnoses or occurrences. These groups may meet on either a regular or an intermittent basis.

Count:
- Costs to run various support groups, (e.g., diseases and disabilities, grief, infertility, patients' families, other)

Do not count:
- Support given to patients and families
- Childbirth education classes that are reimbursed

A12. Self-help
Wellness and health promotion programs offered to the community, such as smoking-cessation, exercise, and weight-loss programs.

Count:
- Anger management
- Exercise
- Mediation programs
- Smoking cessation
- Stress management
- Weight loss and nutrition
- Other

Do not count:
- Health care organization employee wellness and health promotion provided as an employee benefit.

A20. Community-Based Clinical Services
These clinical services are clinical services provided (e.g., free clinics, screenings, or one-time events) to the community. This category does NOT include permanent subsidized hospital outpatient services. (Report this in C Mission Driven Health Services).

A21. Screenings
Screenings are health tests that are conducted in the community as a public clinical service, such as blood pressure measurements, cholesterol checks, school physicals and other events. They are

a secondary prevention activity designed to detect the early onset of illness and disease and can result in a referral to any community medical resource.

Count:

- Behavioral health screenings
- Blood pressure screening
- Lipid profile and/or cholesterol screening
- Eye examinations
- General screening programs
- Health risk appraisals
- Hearing screenings
- Mammography screenings, if not a separate free-standing breast diagnostic center (then report in section C5)
- Osteoporosis screenings
- School physical examinations
- Skin cancer screening
- Stroke risk screening
- Other screenings

Do not count:

- Health screenings associated with conducting a health fair (report in category A1)
- Screenings for which a fee is charged, unless there is a negative margin

A22. One-Time or occasionally held clinics

Count:

- Blood pressure and/or lipid profile/cholesterol screening clinics
- Cardiology risk factor screening clinics
- Colon cancer screening clinics
- Dental care clinics
- Immunization clinics
- Mobile units that deliver primary care to underserved populations on an occasional or one-time basis
- One time or occasionally held primary care clinics
- School physical clinics
- Stroke screening clinics
- Other clinics

Do not count:

- Screenings in which a fee is charged and a profit is realized (do report if there is a negative margin)
- Permanent, ongoing, hospital-sponsored programs (these should be counted in subsidized health services C, Mission Driven Health Services)

A23. Free Clinics

Free clinics are staff and resource costs that support non-healthcare organization sponsored community health centers and clinics, such as federally qualified community health centers. (Hospital sponsored clinics should be reported under C. Mission Driven Health Services. Medical residency clinic costs should be reported under B. Medical Education)

Count:

- Hospital subsidies such as grants
- Costs for staff time, equipment, overhead costs
- Lab and medication costs

Do not count:

- Volunteers' time and contributions by other community partners

A24. Mobile Units

Count:

- Vans and other mobile units used to deliver primary care services

Do not count:

- Mobile specialty care services that are an extension of the organization's outpatient department, e.g., mammography, radiology, lithotripsy, etc. (report in C, Mission Driven Health Services)

A30. Health Care Support Services

Health care support services are given on a one-on-one basis to assist community members.

Count:

- **Enrollment assistance in public programs, including state, indigent, and Medicaid and Medicare programs (Maryland's uniqueness with regard to UCC is being considered by HSCRC staff and will be discussed further before being included or excluded.)**
- Information and referral to community services
- Telephone information services (Ask a Nurse, medical and mental health service hot-lines, poison control centers)
- Transportation programs for patients and families to enhance patient access to care (include cab vouchers provided to patients and families)

Do not count:

- Physician referral if it is primarily an internal marketing effort (include if the call center refers to other community organizations or to physicians from across an area without regard to admitting practices)
- Health care support given to patients and families in the course of their inpatient or outpatient encounter
- Discharge planning

A40-A44 Other

Other areas include community benefit initiatives and programs where the recipient is not billed. Please list each program separately and include only those programs that were not reported elsewhere in a different community benefit reporting category.

Count:

- Free Medications or medication subsidies/vouchers (if provided as part of a non-healthcare organization sponsored free health care clinic, such as a FQHC, report under A20 Community Based Clinical Services)

B00. HEALTH PROFESSIONS EDUCATION

As a reminder, Maryland law defines a community benefit as an activity that is "intended to address community needs and priorities primarily through disease prevention and improvement of health status."

Additionally, please remember that offsetting revenue provided in the form of HSCRC-approved rates should not be reported in the "Offsetting Revenue" column.

B10. Physicians/Medical Students

Count:

- A clinical setting for undergraduate/vocational training
- Internships/clerkships/residencies
- Residency education
- Fellows that are paid for by the hospital

Do not count:

- Expenses for physician and medical student in-service training
- Joint appointments with educational institutions, medical schools
- Orientation programs
- Continuing medical education (CME) costs

B20. Nurses/Nursing Students

Count:

- Funding, including registrations, fees, travel, and incidental expenses for staff education, that is linked to community services and health improvement
- Nursing scholarships or tuition payments for professional education to non-employees and volunteers

Do not count:

- Costs for staff conferences and travel other than above
- Financial assistance for employees who are advancing their own educational credentials
- Tuition reimbursement costs provided as an employee benefit

B30. Other Health Professionals

Count:

- The provision of a clinical setting for undergraduate/vocational training to students enrolled in an outside organization
- Internships/externships when on-site training of nurses (e.g., LVN, LPN) is subsidized by the health care organization

- Do not count expenses associated with:
- Education required by staff, such as orientation, in-service programs, new grad training
- Expenses for standard in-service training and in-house mentoring programs
- In-house nursing and nurse's aide training programs
- Staff costs associated with joint appointments with educational institutions, nursing schools

B40. Scholarships/Funding for Professional Education

Count:

- A clinical setting for undergraduate training for lab and other technicians

Do not count expenses associated with:

- Education required by staff such as orientation, in-service programs
- Expenses for standard in-service programs
- Joint appointments with educational institutions, schools of medical technology, etc.

B50 – B53. Other

Count:

- A clinical setting for undergraduate training for dietitians, physical therapists, pharmacists, and other health professionals
- Training of health professionals in special settings (occupational health, outpatient facilities, etc.)
- Internships for pastoral education, social service, dietary and other professional/instructional internships
- Medical translator training
- Program costs associated with high school student "job shadowing" and mentoring projects
- Recruitment/retention of underrepresented minorities
- Scholarships to community members (not employees)
- Specialty in-service and videoconferencing programs made available to professionals in the community

Do not count expenses associated with:

- Education required by staff, such as orientation, in-service programs
- Expenses for standard in-service training

- Joint appointments with educational institutions, schools of physical therapy, etc.
- On-the-job training such as pharmacy technician and nurse's assistant programs
- Orientation programs
- Staff time delivering care concurrent with "job shadowing" and mentoring projects
- Staff tuition reimbursement
- Standard in-service education

C00. MISSION DRIVEN HEALTH SERVICES

C10-C91 Mission driven health services are services provided to the community that were never expected to result in cash inflows but: 1) which the hospital undertakes as a direct result of its community or mission driven initiatives; or 2) would otherwise not be provided in the community if the hospital did not perform these services.

VHA and CHA provide further guidance in the Community Benefit Reporting guidelines that this category should not be viewed as a "catch-all" category for any service that operates at a loss. Care needs to be taken to ascertain whether the negative contribution is truly a community benefit. The Commission would reiterate that those initiatives geared towards increasing a hospital's market share or that are a part of the hospital's routine cost of doing business should not be included in a hospital's community benefit report.

As a reminder, Maryland law defines a community benefit as an activity that is "intended to address community needs and priorities primarily through disease prevention and improvement of health status." Please also refer to pages 6 & 7 of these guidelines to the checklist of questions developed by VHA and CHA to answer possible questions of whether an activity is appropriately considered a community benefit.

For hospitals that are considering reporting physician subsidies, remember to include only those costs that are not part of the hospital's routine cost of doing business but are, rather, community benefit activities that arise as a result of the hospital's tax exempt status. Remember to specifically designate those costs attributable in a separate line distinct from other mission driven health services within Section C.

Whenever possible, classify physician subsidies into the following categories:

- hospital-based physicians with whom the hospital has an exclusive contract and/or subsidy in order to retain services that represent a community benefit;
- Non-Resident house staff and hospitalists;
- Coverage of Emergency Department call;
- Physician provision of financial assistance to encourage alignment with hospital financial assistance policies; and
- Recruitment of physicians to meet community need as shown by a hospital's medical staff development plan

Other costs as appropriate can be included so long as supplemental documentation describing the service and community need being met is provided. Also to the degree possible, categorize physician staffing of community-based clinics that serve underserved populations or otherwise meet unmet community need under section A20. Community Clinics.

TO THE EXTENT POSSIBLE, PLEASE NOTE FOR CATEGORIES 1, 2, AND 3 WHETHER THE SUBSIDIES ARE DIRECTED TOWARDS OBSTETRICS, MENTAL HEALTH (PSYCHIATRIC CARE), PRIMARY CARE, OR SPECIALTY CARE.
To the extent possible, please note for categories

Remember to include only items that generate a negative margin and that have not been otherwise accounted for in a separate Community Benefit reporting section. Report costs using financial statements for initiatives such as:

- Organizationally owned health care clinics or urgent care centers
- Hospice services
- Outpatient mental health services

Do not report:

- Bad debt
- Hospital based Charity care

D00. RESEARCH

Research includes clinical and community health research, as well as studies on health care delivery. In this category, count the difference between operating costs and external subsidies such as grants (negative margin). As a reminder, Maryland law defines a community benefit as an activity that is "intended to address community needs and priorities primarily through disease prevention and improvement of health status."

D10. Clinical Research

Count:

- Unreimbursed studies on therapeutic protocols
- Evaluation of innovative treatments
- Research papers prepared by staff for professional journals
- Other

D20. Community Health Research

Count:

- Studies on health issues for vulnerable persons
- Studies on community health, incidence rates of conditions for populations
- Research papers prepared by staff for professional journals
- Other

D30-D32 Other

Count:

- Research studies on innovative health care delivery models

E00. Cash and In-Kind Contributions

This category includes funds and in-kind services donated to individuals and/or the community at large. This category was formerly called donations. In-kind services include hours donated by staff to the community while on health care organization work time, overhead expenses of space donated to not-for-profit community groups for meetings, etc., and donation of food, equipment and supplies. **This category is restricted to funds allocated to Community Benefits, as is reported on the IRS 990 Schedule H.**

E10. Cash Donations

Count:

- Contributions and/or matching funds provided to not-for-profit community organizations
- Contributions and/or matching funds provided to local governments
- Contributions for not-for-profit event sponsorship
- Contribution/fees paid for golf tournaments, concerts, galas, dinners and other charity events to not-for-profit organizations after subtracting value of participation by employees/organization
- Contributions provided to individuals for emergency assistance
- Scholarships to community members not specific to health care professions

Do not count:

- Employee-donated funds
- Emergency funds provided to employees
- Fees for sporting event tickets, such football, basketball, etc.

E20. Grants

Count:

- Contributions and/or matching funds provided as a community grant to not-for-profit community organizations, projects, and initiatives. Include:
- Program grants
- Operating grants
- Education and training grants
- Matching grants
- Event sponsorship
- General contributions to nonprofit organizations/community groups

E30. In-Kind Donations

Count:

- Meeting room overhead/space for not-for-profit organizations and community (e.g. coalitions, neighborhood associations, social service networks)
- Equipment and medical supplies
- Emergency medical care at a community event

- Costs of coordinating community events not sponsored by the health care organization, e.g., March of Dimes Walk America. (Report health care organization-sponsored community events under G1, Community Benefit Operations)
- Provision of parking vouchers for patients and families in need
- Employee costs associated with board and community involvement on work time
- Food donations, including Meals on Wheels and donations to food shelters
- Gifts to community organizations and community members (not employees)
- Laundry services for community organizations
- Technical assistance, such as information technology, accounting, human resource process support, planning and marketing
- Blood Drive at your facility (cost of the employees' time, food/canteen expense)
- Supplies provided in aid to community outside of your service area in answer to public call for assistance.

Do not count:

- Employee costs associated with board and community involvement when it is the employee's own time and he or she is not engaged on behalf of his or her organization
- Volunteer hours provided by hospital employees on their own time for community events (belongs to volunteer, not the health care organization)
- Health care organization laundry expenses
- Promotional and marketing costs concerning the health care organization's services and programs. These expenses are considered employee benefit
- Salary expenses paid to employees deployed on military services or jury duty. These expenses are considered employee benefit.

E40. Cost of Fund-Raising for Community Programs

This category is meant to capture the costs of raising funds for community benefit programs, and not to capture all fundraising costs of the hospital.

Count:

- Grant writing and other fund-raising costs specific to community benefit programs and resource development assistance not captured under category G., Community Benefit Operations

F00. COMMUNITY-BUILDING ACTIVITIES

Community-building activities include cash, in-kind donations, and budgeted expenditures for the development of community health programs and partnerships. When funds or donations are given directly to another organization, count in E. Donations.

Please keep in mind that you must be able to tie these activities back to an assessed need within the community and the action plan developed to address those needs.

Remember to subtract any subsidies or grant amounts from total expenses incurred in this category.

F10. Physical Improvements and Housing

Count:

- Community gardens
- Neighborhood improvement and revitalization projects
- Public works, lighting, tree planting, graffiti removal
- Housing rehabilitation, contributions to community-based assisted living, senior and low income housing projects
- Habitat for Humanity
- Smoke detector installation programs
- Other

Do not count:

- Housing costs for employees
- Projects having their own community benefit reporting process: e.g., a senior housing program that issues a community benefit report

F20. Economic Development

Count:

- Small business development
- Participation in economic development council, chamber of commerce
- Other

Do not count:

- Routine financial investments

F30. Community Support

Count:

- Adopt-a-school efforts
- Child care for community residents with qualified need
- Mentoring programs
- Neighborhood systems, watch groups
- Youth Asset Development initiatives, including categories of caring adults, safe places, healthy start, marketable skills, and opportunities to serve (America's Promise)
- Disaster readiness
    - Costs as they relate to changes made to accommodate prospective disasters, including costs associated with lockdown capability, enhanced security measures, package handling, air machines and filters, water purification equipment, expanded mortuary facilities, facilities for personnel quarantine, expanded patient isolation facilities, shower facilities, and storage space for stockpiles
    - Costs of creating new or refurbishing existing decontamination facilities, such as water supply communications facility and equipment costs, equipment changes to

ensure interoperability of communications systems; and additional disaster-related purchase of pagers, cell phones, mobile data terminals, and laptop computers specific to the communications component of the disaster plan. Include depreciation expenses.

- Community disease surveillance and reporting infrastructure, updating laboratory diagnostic capability and associated training for laboratory personnel, informatics updating and patient tracking systems, detection instruments/monitors to detect radiation, and tests/assays for detection of chemical agents and toxic industrial materials, as well as tests for identification of biologic agents
- Purchase of personal protective equipment (PPE) for stockpiles, including gloves, masks, gowns, and other items
- Facility areas, waste water containment systems, decontamination tables, storage, shower systems, tents, soap, dispensers, and linen
- Costs of stockpiling medical, surgical, and pharmaceutical supplies, including barriers, respirators, clothing, IV pumps and poles, IV fluids, suction machines, stretchers, wheelchairs, linens, bandages, and dressings
- Costs associated with new or expanded training, task force participation, and drills
- Mental health resource costs associated with training, community partnerships, and outreach planning
- Other

Do not count:

- Costs associated with subsidizing salaries of employees deployed in military action (this is considered employee benefit)
- Costs associated with routine disaster preparedness

F40. Environmental Improvements

Count:

- Efforts to reduce environmental hazards in the air, water, and ground
- Residential improvements (lead, radon programs)
- Neighborhood, community (air pollution, toxin removal in parks)
- Community waste reduction and sharps disposal programs
- Health care facility (waste and mercury reduction, green purchasing, other)
- Other

F5. Leadership Development/Training for Community Members

Count:

- Conflict resolution
- Community leadership development
- Cultural skills training
- Language skills/development
- Life/civic skills training programs
- Medical interpreter training for community members

- Other

Do not count:

- Interpreter training programs for hospital staff, as required by law

F60. Coalition Building

Count:

- Hospital representation to community coalitions
- Collaborative partnerships with community groups to improve community health
- Community coalition meeting costs, visioning sessions, task force meetings
- Costs for task force specific projects and initiatives

F70. Advocacy for Community Health Improvements

Count:

- Local, state, and/or national advocacy for community members and groups relative to policies and funding to improve:
    - Access to health care
    - Public health
    - Transportation
    - Housing
    - Other

Do not count:

- Advocacy specific to hospital operations/financing

F80. Workforce Development

Count:

- Recruitment of physicians and other health professionals for federally medical underserved areas
- Recruitment of underrepresented minorities
- Job creation and training programs
- Participation in community workforce boards, workforce partnerships and welfare-to-work initiatives
- Partnerships with community colleges and universities to address the health care work force shortage
- Workforce development programs that benefit the community, such as English as a Second Language (ESL)
- School-based programs on health care careers
- Community programs that drive entry into health careers and nursing practice
- Community-based career mentoring and development support

Do not count:

- Routine staff recruitment and retention initiatives

- In-service education and tuition reimbursement programs for current employees
- Scholarships for nurses and other health professionals (count in B Health Professions Education)
- Scholarships to community members not specific to health care professions (count in E1, Cash)
- Employee workforce mentoring, development, and support programs

F90-F92. Other

Please list each program separately and include only those programs that were not reported elsewhere in a different community benefit reporting category.

G00. COMMUNITY BENEFIT OPERATIONS

Community benefit operations include costs associated with dedicated staff, community health needs and/or assets assessment, and other costs associated with community benefit strategy and operations.

G10. Assigned Staff

Count:

- Staff costs of management/oversight of community benefit program activities that are not included in other community services categories
- Staff costs for internal tracking and reporting community benefit
- Staff costs to coordinate community benefit volunteer programs

Do not count:

- Staff time to coordinate in-house volunteer programs, including outpatient volunteer programs
- Volunteer time of individuals for community benefit volunteer programs

G20. Community health needs/health assets assessment

Count:

- Community health needs assessment
- Community assessments, such as a youth asset survey

Do not count:

- Costs of a market-share assessment and marketing survey process
- Economic impact survey costs or results

G30-G32. Other

Count:

- Cost of evaluation efforts of community benefits initiatives or programs
- Cost of fund-raising for hospital-sponsored community benefit programs, including grant writing and other fund-raising costs
- Cost of grant writing and other fund-raising costs of equipment used for hospital-sponsored community benefit services and activities
- Costs associated with developing a community benefit plan, conducting community forums, and reporting community benefit
- Overhead and office expenses associated with community benefit operations exclusive of fundraising
- Dues to an organization that specifically support the community benefit program, such as the Association for Community Health Improvement
- Software that supports the community benefit program
- Costs associated with attending educational programs to enhance community benefit program planning and reporting

Do not count:

- Recognition/awards for volunteer staff
- Grant writing and other fund-raising costs of hospital projects (such as capital funding of buildings and equipment) that are not hospital community benefit programs
- Dues to hospital and professional organizations not specifically and directly related to community benefit
- Software not specifically and directly purchased to support the community benefit program
- Costs associated with attending education programs that are not specifically and directly related to community benefit

H99. CHARITY CARE

Charity care is:

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

Charity care results from a provider's policy to provide health care services free of charge, or on a discounted fee schedule, to individuals who meet certain financial criteria. Generally, a bill must be generated and recorded and the patient must meet the organization's criteria for charity care, and demonstrate an inability to pay.

Charity care does not include bad debt. Bad debt is uncollectible charges excluding contractual adjustments, arising from the failure to pay by patients whose health care has not been classified as charity care.

Do not count:

- Bad debt
- Costs already included in the Mission Driven Health Care Services category

III. OTHER GUIDELINES

I00. FINANCIAL DATA

In terms of financial accounting practices, hospitals should use audited financial statements as the source. Hospitals with a fiscal year that coincides or closely coincides with the HSCRC's required Community Benefit reporting period of July 1 to June 30 should report Community Benefit data using the most recent audited financial statements as the source.

Hospitals whose fiscal year is calendar-year based should also collect community benefit information for the reporting period of July 1 through June 30. Since a calendar year hospital's audited financial statements will not be completed by January 1 of the following year, however, the Commission understands that all information contained within the Community Benefit Report may not directly correlate to final audited figures. A hospital should make clear in its Community Benefit Report submission, therefore, the types of financial data used and time periods covered. Every effort should be made to have these reported figures directly tie to the hospital's financial statements.

I10. INDIRECT COSTS

Hospitals can currently calculate an indirect cost ratio from their HSCRC Annual Cost Report data. This can be calculated using Schedule M from the hospital's Annual Cost Report. Hospitals should calculate an indirect cost ratio from their HSCRC Annual Cost Report data (please see pages 4 & 5 for instructions on how to calculate an indirect cost ratio). Please enter this calculated number into Item I10. Please enter this calculated number as a whole number, not as a percentage. The spreadsheet will convert the number into a percentage.

Rather than calculating a separate indirect cost per activity, the HSCRC inventory spreadsheet permits hospitals to calculate an indirect cost ratio calculated by the hospital and entered into Item I1, which can then be used to allocate indirect costs to the following community benefit categories: (A) Community Health Services; (F) Community Building Activities; and (G) Community Benefit Operations.

The HSCRC asks that hospitals examine its calculated indirect costs carefully, and to override the calculated indirect costs where the hospital believes the direct costs may, in part, reflect the total costs of the community benefit initiative. For the remaining categories, the indirect cost

calculation will default to zero, and may be overridden if the hospital believes there are indirect costs involved with the initiative, but are not accurately represented in the direct costs.

J00. FOUNDATION-FUNDED COMMUNITY BENEFIT

A foundation is a separate not-for-profit organization affiliated with the health care organization that conducts fund-raising. A foundation can support health care organization operations and/or may fund community health improvement programs, activities, and research. Alignment of foundation (philanthropy) and community health improvement demonstrates commitment to mission and advances business goals while improving community health. Foundation-funded community benefit is defined as significant community benefit activities, including community health improvement initiatives, school-based clinics, community partnership development, and other areas that are funded by the foundation. Foundation departments that are part of the health care organization operations should record community benefit activity in the health care organization sections.

J10. Community Services

Community health services include activities carried out to improve community health. They extend beyond patient care activities and are usually subsidized by the health care organization. Community services do not generate inpatient or outpatient bills, although there may be a nominal patient fee and/or sliding scale fee. Forgiving inpatient and outpatient care bills to low-income persons should be reported as charity care.

Count:

- Community health education
- Community-based clinical services
- Support groups
- Health care support services
- Self help
- Other

More detail regarding community health services to quantify can be found in sections A1 to A6 of this document.

J20. Community Building

Community building activities include cash, in-kind donations, and budgeted expenditures for the development of community health programs and partnerships. Remember to subtract any subsidies or grant amounts from total expenses incurred in this category.

Count:

- Physical improvements

- Economic development
- Support system enhancements
- Environmental improvements
- Leadership development and skills training
- Coalition building
- Community health improvement advocacy
- Workforce enhancement
- Other

J30-J32. Other

Count:

- Community Benefit operations cost
- Any other community benefit programs or services that do not fit within sections J10 or J20

K00. Total Hospital Community Benefit

For this section, the worksheet cells are formula driven utilizing hospital-specific data provided. Therefore, no numbers will need to be entered by the hospital in this section.

IV. DO NOT COUNT!

The following are frequently posed scenarios that the Community Benefit Report Guidelines developed by the VHA, CHA, and Lyon software recommend NOT COUNTING:

- Activities specifically geared to increase market share
- Facility anniversary celebrations
- Grand opening events, dedications, and related activities for new services and facilities
- Nurse call lines paid for by payers or physicians
- Providing copies of medical records, x-rays
- Providing continuing medical education (CME), orientation, and in-service education
- Discharge planning
- Salary expenses paid to employees deployed for military services or jury duty. These expenses are considered employee benefits
- Promotional and marketing information about health care organization services and programs
- Social services for patients
- Problem resolution and referral of issues related to health system services
- Cardiac rehabilitation services
- Token of sympathy to staff or patients at times of crisis or bereavements (e.g., flowers, cards, meals)
- Free or discounted immunizations and other health services to staff (employee benefit)
- Providing information on services provided by the health system at a health fair or mall
- Decorating facilities for the holidays

- In-house pastoral care
- Free meals and meal discounts for volunteers and/or employees
- Free parking for clergy, volunteers
- Medical library (include percentage of costs only if there is a significant consumer health library focus)
- Staff donations to assist other staff
- Pharmacy discounts for employees and volunteers
- Reimbursed home health care services
- Staff volunteering (report only volunteer efforts done on work time)
- Volunteer time by community volunteers for either in-house OR community efforts (it is their time, not the health care organization's)
- Professional education such as in-services and cost for professional conferences
- Economic impact of employee payroll and purchasing dollars
- Employee contributions such as United Way or Adopt a Family at Christmas
- Physician referral if it is more of an internal marketing effort (include if it refers to many community organizations or to physicians from across an area, with regard to admitting practices)
- Hospital tours
- Amenities for visitors such as coffee in the waiting rooms, etc.
- Costs incurred for inpatient health education
- Costs associated with provision of day care services for employees
- Employee costs associated with board and community involvement when it is the employee's own time for personal or civic interests
- Costs associated with subsidizing salaries of employees deployed in military action (this is considered an employee benefit)
- Staff presenting to professional organizations
- Tuition reimbursement costs provided as an employee benefit
- Nurses teaching/delivering papers at professional meetings

V. COMMUNITY BENEFIT DEFINITIONS [1]

Bad Debt

Uncollectible charges, excluding contractual adjustments, arising from the failure to pay by patients whose health care has not been classified as charity care. Bad debt is not community benefit.

Bioterrorism

The intentional use, or threatened use, of viruses, bacteria, fungi, toxins from living organisms, or chemicals to produce death and/or disease in humans and living systems.

Broader Community

Broader community means persons other than a "target population" who benefit from a health care organization's community services and programs.

Charity Care

Charity care is:

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

Charity care results from a provider's policy to provide health care services free of charge or discounted to individuals who meet certain financial criteria. Generally, a bill must be generated and recorded and the patient must meet the organization's criteria for charity care, and demonstrate an inability to pay. Charity care does not include bad debt.

Community

"Community" describes all persons and organizations within a circumscribed geographic area in which there is a sense of interdependence and belonging. The term broader community refers to persons other than a "target population" who benefit from a health care organization's community services and programs.

Community-Based Clinical Services

[1] These definitions are drawn directly from the collaboration among VHA Inc., the Catholic Health Association of the United States, and Lyon Software, which worked to create standardized community benefit categories, definitions, and reporting guidelines in an effort to achieve a national standardized approach for not-for-profit health care organizations.

These clinical services are clinical services provided (e.g., free clinics, screenings, or one-time events) to the community. This category does NOT include permanent subsidized hospital outpatient services.

Community Benefit

A community benefit is a planned, organized, and measured approach, by a non-profit healthcare organization, to meeting identified community health needs within its service area. It most often requires collaboration with other non-profit and public organizations within the community in determining the health needs of its residents. Such planning relies on the use of objective data and information to determine community needs, and the impact of the organization's participation on those needs.

Community benefits respond to an identified community need, and meet the following criteria:

Ultimately improve the health status and well being of specific populations in the organization's service area who are known to have difficulty accessing care and/or who have chronic needs;

Generate a low or negative margin;

Are not provided for marketing purposes; and/or

The service or programs would likely be discontinued if the decision were made on a purely financial basis.

Community Benefit Categories

Community benefit programs and initiatives are quantified in broad categories. These categories are:

- Community Health Services
- Health Professions Education
- Mission Driven Health Services
- Research
- Financial Contributions
- Community Building Activities
- Community Benefit Operations
- Charity care
- Foundation Funded Community Benefit

Community benefit can be quantified for the hospital, health system, and/or dependent foundation.

Community Benefit Operations

Community benefit operations are costs associated with dedicated staff, community health needs and/or assets assessments, and other costs associated with community benefit strategy and operations.

Community Benefit Plan

A community benefit plan is a document, often produced in conjunction with the health care organization's annual strategic plan that explicitly details how an organization intends to fulfill both its mission of community service and its charitable, tax-exempt purpose. It includes a description of community benefit priorities, programs, staffing and resources, and anticipated outcomes.

Community Benefit Programs and Services

Community benefit programs and services are projects and services identified by health care organizations in response to the findings of a community health assessment, strategic and/or clinical priorities, and partnership areas of attention.

Community Building

Community building activities include cash, in-kind donations, and budgeted expenditures for the development of community health programs and partnerships. Enhancements include physical improvements, economic development, healthy community initiatives, partnerships, environmental improvements, and community leadership skills training.

Community Health Assessment

Usually conducted in collaboration with other community groups and organizations, a community health assessment is a structured process for determining the health status and needs of community members, as well as identifying target community health improvement programs and services.

Community Health Education

Community health education includes lectures, presentations, and other programs and activities provided to groups, without providing clinical or diagnostic services. Community benefit in this area can include staff time, travel, materials, and indirect costs.

Community Health Services

Community health services include activities carried out for the express purpose of improving community health. They extend beyond patient care activities and are usually subsidized by the hospital. Community services do not generate inpatient or outpatient bills, although there may be a nominal patient fee and/or sliding scale fee. Forgiving inpatient and outpatient care bills to low-income persons should be reported as charity care.

Continuing Care Services

Continuing care services include hospice home care services, nursing home care, geriatric services, senior day centers, and assisted living.

Counseling

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

Direct Costs

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

Donations

This category includes funds and in-kind services donated to individuals and/or the community-at-large. In-kind services include hours donated by staff to the community while on health care organization work time; overhead expenses of space donated to not-for-profit community groups for meetings, etc.; and donation of food, equipment and supplies.

Foundation

A foundation is a separate not-for-profit organization affiliated with the health care organization that conducts fund-raising. A foundation can support core health care organization operations and/or may fund community health improvement programs, activities, and research. Alignment of foundation (philanthropy) and community health improvement is an emerging strategic alliance that demonstrates commitment to mission and advances business goals while improving community health. Foundation funded community benefit is defined as significant community benefit activities, including community health improvement initiatives, school-based clinics, community partnership development, and other areas that are funded by the foundation. Foundation departments that are part of the health care organization operations should record community benefit activity in the health care organization sections.

Free Clinics

A free clinic provides free or low-cost health care to medically uninsured persons through the use of volunteers, including physicians and health care professionals who donate their time.

Government-Sponsored Health Care

Government-sponsored health care describes services that are reimbursed or partially reimbursed through federal, state, and local programs such as Medicaid, Medicare, and public indigent and health care programs.

Health Care Support Services

Support is given on a one-on-one basis to assist community members.

Indigent

A financially indigent individual is an uninsured or underinsured person who is accepted for care with no obligation (or a discounted obligation) to pay for the services rendered based on the health care organization's eligibility system.

Indirect Costs

Indirect costs are costs not attributed to products and/or services that are included in the calculation of costs for community benefit. These could include but are not limited to human resource and finance departments, insurance, support departments and overhead expenses. (for calculation and detailed explanation, please see Section I).

Immunizations

Immunization services include personnel, equipment, and supplies necessary to provide immunizations to community members and groups.

In-kind Services

In-kind services include hours donated by staff to the community while on health care organization work time, as well as overhead expenses of space donated to not-for-profit community groups for meetings, etc.

Medical Education

Medical education includes the negative margin (the difference between cost and reimbursements) incurred in providing clinical settings, including clinic costs, internships, and programs for physicians, nurses, and health professionals. It also refers to scholarships for health profession education related to providing community health improvement and services and specialty in-service programs to professionals in the community.

Mission Driven Health Services

Mission driven health services are services provided to the community that were never expected to result in cash inflows but: 1) which the hospital undertakes as a direct result of its community or mission driven initiative; and 2) would otherwise not be provided in the community if the hospital did not perform these services.

Mobile Unit

Vans and other mobile units used to deliver primary care services.

Negative Margin

Negative margin is the negative difference between what it costs to offer programs, health care, or services, and any cash or reimbursements received.

Non-billed Services

Non-billed services are activities and services for which no individual patient bills exist. These services are not expected to be financially self-supporting, although some may be supported by outside grants or funding. They can be designed to be offered as a public benefit with charitable or community service intent.

Patient Education

Patent education is health education provided to inpatients and outpatients. For the purposes of standardized reporting, it is recommended that hospitals consider patient education a standard component of health care and not a community benefit.

Research

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

Self-help

Wellness and health promotion programs, such as smoking cessation, exercise classes, and weight-loss programs.

Screenings

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

Self-Help

Self-help refers to wellness and health promotion programs such as exercise classes, smoking cessation and nutrition education.

Support Groups

Support groups typically are established to address social, psychological, or emotional issues related to specific diagnoses or occurrences. These groups may meet on a regular or intermittent basis.

Target Group

A target group is the primary audience for which a program is intended such as infants, children, adolescents, adults, seniors, or the disabled.

COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

Effective for FY2012 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

Updated June 6, 2012

BACKGROUND

The Health Services Cost Review Commission's (HSCRC or Commission) Community Benefit Report, required under §19-303 of the Health General Article, Maryland Annotated Code, is the Commission's method of implementing a law that addresses the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals.

The Commission's response to its mandate to oversee the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulated environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, and (3) hospital community benefit administration.

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Please list the following information in Table I below. For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12 month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all hospitals by the HSCRC.

Table I

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:

2. For purposes of reporting on your community benefit activities, please provide the following information:

   a. Describe in detail the community or communities the organization serves. (For the purposes of the questions below, this will be considered the hospital's Community Benefit Service Area – "CBSA". This service area may differ from your primary service area on page 1. Please describe in detail.)

   b. In Table II, describe significant demographic characteristics and social determinants that are relevant to the needs of the community and include the source of the information in each response. For purposes of this section, social determinants are factors that contribute to a person's current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature. (Examples: gender, age, alcohol use, income, housing, access to quality health care, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary).

   Some statistics may be accessed from the Maryland Vital Statistics Administration (http://vsa.maryland.gov/html/reports.cfm), and the Maryland State Health Improvement Plan (http://dhmh.maryland.gov/ship/).

Table II

Community Benefit Service Area(CBSA) Target Population (target population, by sex, race, and average age)	
Median Household Income within the CBSA	
Percentage of households with incomes below the federal poverty guidelines within the CBSA	
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	
Percentage of Medicaid recipients by County within the CBSA.	

Life Expectancy by County within the CBSA.	
Mortality Rates by County within the CBSA.	
Access to healthy food, quality of housing, and transportation by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources)	
Other	
Other	

II. COMMUNITY HEALTH NEEDS ASSESSMENT

According to the Patient Protection and Affordable Care Act ("ACA"), hospitals must perform a Community Health Needs Assessment (CHNA) either fiscal year 2011, 2012, or 2013, adopt an implementation strategy to meet the community health needs identified, and perform an assessment at least every three years. The needs assessment must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and must be made widely available to the public.

For the purposes of this report and as described in Health General 19-303(a)(4), a community health needs assessment is a written document developed by a hospital facility (alone or in conjunction with others) that utilizes data to establish community health priorities, and includes the following:

(1) A description of the process used to conduct the assessment;
(2) With whom the hospital has worked;
(3) How the hospital took into account input from community members and public health experts;
(4) A description of the community served; and
(5) A description of the health needs identified through the assessment process.

Examples of sources of data available to develop a community needs assessment include, but are not limited to:

(1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (County Health profiles are available on the SHIP website) (http://dhmh.maryland.gov/ship/);
(2) Local Health Departments;
(3) County Health Rankings (http://www.countyhealthrankings.org);
(4) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(5) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(6) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(7) Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(8) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(9) For baseline information, a Community health needs assessment developed by the state or local health department, or a collaborative community health needs assessment involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(10) Survey of community residents
(11) Use of data or statistics compiled by county, state, or federal governments; and
(12) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers. .

1. Identification of community health needs:
   Describe in detail the process(s) your hospital used for identifying the health needs in your community and the resource(s) used.

2. In seeking information about community health needs, what organizations or individuals outside the hospital were consulted?

3. When was the most recent needs identification process or community health needs assessment completed? (this refers to your *current* identification process and may not yet be the CHNA required process)
   Provide date here. __/__ /__ (mm/dd/yy)

4. Although not required by federal law until 2013, has your hospital conducted a Community Health Needs Assessment that conforms to the definition on the previous page within the past three fiscal years? **Please be aware, the CHNA will be due with the FY 2013 CB Report.
   ___Yes
   ___No

   If you answered yes to this question, please provide a link to the document or attach a PDF of the document with your electronic submission.

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

a. Is Community Benefits planning part of your hospital's strategic plan?

___Yes
___No

b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and provide additional information if necessary):

i. Senior Leadership

1. ___CEO
2. ___CFO
3. ___Other (please specify)

ii. Clinical Leadership

1. ___Physician
2. ___Nurse
3. ___Social Worker
4. ___Other (please specify)

iii. Community Benefit Department/Team

1. ___Individual (please specify FTE)
2. ___Committee (please list members)
3. ___Other (please describe)

c. Is there an internal audit (i.e., an internal review conducted at the hospital) of the Community Benefit report?

Spreadsheet _____yes _____no
Narrative _____yes _____no

d. Does the hospital's Board review and approve the completed FY Community Benefit report that is submitted to the HSCRC?

Spreadsheet	_____yes	_____no
Narrative	_____yes	_____no

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

1. Please use Table III (see attachment) to provide a clear and concise description of the needs identified in the process described above, the initiative undertaken to address the identified need, the amount of time allocated to the initiative, the key partners involved in the planning and implementation of the initiative, the date and outcome of any evaluation of the initiative, and whether the initiative will be continued. Use at least one page for each initiative (at 10 point type).

For example: for each major initiative where data is available, provide the following:

   a. Identified need: This includes the community needs identified in your most recent community health needs assessment as described in Health General 19-303(a)(4).

   b. Name of Initiative: insert name of initiative.

   c. Primary Objective of the Initiative: This is a detailed description of the initiative and how it is intended to address the identified need. (Use several pages if necessary)

   d. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?

   e. Key Partners in Development/Implementation: Name the partners (community members and/or hospitals) involved in the development/implementation of the initiative. Be sure to include hospitals with which your hospital is collaborating on this initiative.

   f. Date of Evaluation: When were the outcomes of the initiative evaluated?

   g. Outcome: What were the results of the initiative in addressing the identified community health need, such as a reduction or improvement in rate? (Use data when available).

   h. Continuation of Initiative: Will the initiative be continued based on the outcome?

   i. Expense: What were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.

2. Were there any primary community health needs that were identified through a community needs assessment that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an identified community need, or lack of resources related to prioritization and planning.)

V. PHYSICIANS

1. As required under HG§19-303, provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand. The 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.

VI. APPENDICES

To Be Attached as Appendices:

1. Describe your Charity Care policy:
    a. Describe how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's charity care policy. (label appendix 1)

    For ***example***, state whether the hospital:

    - posts its charity care policy, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
    - provides a copy of the policy, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
    - provides a copy of the policy, or summary thereof, and financial assistance contact information to patients with discharge materials;
    - includes the policy, or a summary thereof, along with financial assistance contact information, in patient bills; and/or
    - discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

    b. Include a copy of your hospital's charity care policy (label appendix 2).

2. Attach the hospital's mission, vision, and value statement(s) (label appendix 3).

Table III
Revised 060612

Initiative 1.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY? (See Instructions)

Table III
Revised 060612

Initiative 2.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY? (See Instructions)

Table III
Revised 060612

Initiative 3.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY? (See Instructions)

Table III
Revised 060612

Initiative 4.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY? (See Instructions)

Table III
Revised 060612

Initiative 5.

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY? (See Instructions)

Community Benefit Reporting Narrative Evaluation Criteria – Effective FY 2012 reporting period.

Hospital Name: _____ Point Total: _____ out of 139 pts.

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARATERISTICS - total 12 pts

1. What was the licensed bed designation, number of inpatient admissions, the primary service area, and primary service area overlap with other hospitals in the fiscal year? (0 pts)
2. For purposes of reporting on your community benefit activities, describe the community your organization serves.
    a. Is the Community Benefit Service Area (CBSA) described in appropriate detail?
    ___ (0-6 pts)

    b. Are the significant demographic characteristics that are relevant to the needs that the hospital seeks to meet described?
    ___ (0-6 points)

II. COMMUNITY HEALTH NEEDS ASSESSMENT - total 25 pts

1. Are the process(s) and resource(s) used for indentifying the health needs in the community described in appropriate detail?
    ___ (0-10 pts)

2. Did the hospital consult with outside organizations and individuals to seek information about community health needs? Scoring should be based on the breadth and appropriateness of these consults.

    ___ (0-10 pts)

3. Is the date of the most recent needs identification process or community health needs assessment provided?
    ___ Yes (5 pts)
    ___ No (0pts)

4. Although not required by federal law until 2013, did the hospital conduct a community health needs assessment that conforms to the definition in the narrative instructions, in the past three fiscal years?

    ___Yes
    ___No

III. COMMUNITY BENEFIT ADMINISTRATION– total 32 pts

1. Does the report indicate who was involved in the decision making process for determining which needs in the community would be addressed through the Community Benefit activities?

   a. Does the hospital have a CB strategic plan?
   ___Yes (5 pts)
   ___No (0 pts)

   b. Are the following included in the process/structure of implementing and delivering Community Benefit Activities?

   i. Senior Leadership
   ___ Yes (5 pts)
   ___ No (0 pts)

   ii. Clinical Leadership
   ___ Yes (5 pts)
   ___ No (0 pts)

   iii. Community Benefit Department/Team
   ___ Yes (5 pts)
   ___ No (0 pts)

   c. Does the hospital conduct an internal audit the Community Benefit Report

   i. Spreadsheet:
   ___Yes (3 pts)
   ___No (0 pts)

   ii. Narrative:
   ___Yes (3 pts)
   ___No (0 pts)

   d. Does the hospital Board review and approve the completed Community Benefit Report

   i. Spreadsheet:
   ___Yes (3 pts)
   ___No (0 pts)

   ii. Narrative:

   ___ Yes (3 pts)
   ___No (0 pts)

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES – Total of 50 pts

1. Does the report describe in sufficient detail the identified community needs and initiatives undertaken by the hospital?

   ___ (0-20)

   Does the report describe in sufficient detail the timing, key partners, process for evaluation, and outcomes of the key initiatives?

   ___ (0-20)

2. Does the report provide a list of needs that were identified through a community needs assessment but were not addressed by the hospital? If not, was there appropriate justification?

   ___ (0-10)

V. PHYSICIANS – Total of 5 pts

1. Does the report include a written description of the gaps in availability of specialist providers to serve the uninsured cared for by the hospital?
   ___Yes (5 pts)
   ___No (0 pts)

2. If the hospital listed physician subsidies in Category C, did the hospital provide detail on those subsidies?
   ___Yes
   ___No

VI. APPENDICIES Total – 15 pts

1. Charity Care Policies:
   a. Appendix I – Did the hospital describe how it informs patients about eligibility for assistance under the hospital's charity care policy?

      ___Yes (5 pts)
      ___No (0 pts)

   b. Appendix II – Did the hospital attach a copy of the Charity Care Policy?
      ___Yes (5 pts)
      ___No (0 pts)

2. Mission, Vision and Value statements
   a. Appendix III – Did the hospital attach a copy of the mission, vision, and value statement?
      ___ Yes (5 pts)
      ___ No (0 pts)

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

Authority: Health-General Article, §§ 19-207, 19-212, and 19-215; Annotated Code of Maryland

NOTICE OF FINAL ACTION

On June 6, 2012, the Health Services Cost Review Commission adopted amendments to Regulation **.02** under **COMAR 10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions.** This action, which was proposed for adoption in 39.8 Md. R. 539-540 (April 20, 2012), has been adopted as proposed.

Effective Date: **July 9, 2012**

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

Improvement Commission, including the availability of mediation services and the potential for compensation for certain losses from the Guaranty Fund. The required notice also informs homeowners that they may request a home improvement contractor to purchase a performance bond in order to receive additional protection against loss beyond the protection offered by the Guaranty Fund. Contractors may comply with these requirements by attaching an addendum, signed by both parties, to pre-preprinted contracts until July 1, 2013. After that date, the notices must be included in the contract.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Steven Smitson, Executive Director, Maryland Home Improvement Commission, 500 N. Calvert Street, Room 306, Baltimore, MD 21202, or call 410-230-6169, or email to ssmitson@dllr.state.md.us, or fax to 410-962-8482. Comments will be accepted through May 23. 2012. A public hearing has not been scheduled.

Open Meeting

Final action on the proposal will be considered by the Maryland Home Improvement Commission during a public meeting to be held on June 7, 2012, at 10 a.m., at 500 N. Calvert Street, Baltimore, MD 21202.

.26 Required Notice in Contracts.

A. A home improvement contract shall contain a notice stating that:

(1) Formal mediation of disputes between homeowners and contractors is available through the Maryland Home Improvement Commission;

(2) The Maryland Home Improvement Commission administers the Guaranty Fund, which may compensate homeowners for certain actual losses caused by acts or omissions of licensed contractors; and

(3) A homeowner may request that a contractor purchase a performance bond for additional protection against losses not covered by the Guaranty Fund.

B. The notice required by this regulation shall be included within the contract or, until July 1, 2013, may be included in an addendum attached to the contract, provided that the addendum is signed by the homeowner and contractor.

JOHN BORZ
Chair, Home Improvement Commission

Title 10
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

Authority: Health-General Article, §§19-207, 19-212, and 19-215, Annotated Code of Maryland

Notice of Proposed Action

[12-098-P-I]

The Health Services Cost Review Commission proposes to amend Regulation **.02** under **COMAR 10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on March 7, 2012, notice of which was given pursuant to State Government Article, §10-506(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about July 9, 2012.

Statement of Purpose

The purpose of this action is to update the Commission's manual entitled "Accounting and Budget Manual for Fiscal and Operating Management (August, 1987)", which has been incorporated by reference.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Diana Kemp, Administrator II, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, MD 21215, or call 410-764-2576, or email to dkemp@hscrc.state.md.us, or fax to 410-358-6217. Comments will be accepted through May 21, 2012. A public hearing has not been scheduled.

Editor's Note on Incorporation by Reference

Pursuant to State Government Article, §7-207, Annotated Code of Maryland, the Accounting and Budget Manual for Fiscal and Operating Management (August, 1987), Supplement 21, has been declared a document generally available to the public and appropriate for incorporation by reference. For this reason, it will not be printed in the Maryland Register or the Code of Maryland Regulations (COMAR). Copies of this document are filed in special public depositories located throughout the State. A list of these depositories was published in 39:2 Md. R. 104 (January 27, 2012), and is available online at www.dsd.state.md.us. The document may also be inspected at the office of the Division of State Documents, 16 Francis Street, Annapolis, Maryland 21401.

.02 Accounting System; Hospitals.

A. The Accounting System.

(1) (text unchanged)

(2) The "Accounting and Reporting System for Hospitals", also known as the Accounting and Budget Manual for Fiscal and Operating Management (August, 1987), is incorporated by reference, including the following supplements:

(a) — (r) (text unchanged)

(s) Supplement 19 (February 9, 2010); and

(t) Supplement 20 (May 16, 2011)*; and*

(u) Supplement 21 (June 5, 2012).

(3) — (5) (text unchanged)

B. — D. (text unchanged)

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

Title 12
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

Subtitle 10 CORRECTIONAL TRAINING COMMISSION

Notice of Proposed Action

[12-099-P]

The Secretary of Public Safety and Correctional Services proposes to:

(1) Amend Regulations **.04—.06**, **.09**, and **.14—.17**, repeal existing Regulations **.19**, **.20**, **.25**, and **.26**, amend and recodify existing Regulation **.24** to be Regulation **.22**, and recodify existing Regulations **.21—.24** and **.27** to be Regulations **.19—.22** and **.23** under **COMAR 12.10.01 General Regulations**;

(2) Repeal existing Regulations **.01—.31** and adopt new Regulations **.01—.10** under **COMAR 12.10.04 Firearms Training**;

(3) Amend Regulation **.01** under **COMAR 12.10.05 Electronic Control Device Training and Instructor Certification**; and

(4) Adopt new Regulations **.01—.16** under a new chapter, **COMAR 12.10.06 Instructor Training and Certification**.

This action was considered by the Correctional Training Commission at a public meeting on January 24, 2012.

Statement of Purpose

The purpose of this action is to separate two distinct Correctional Training Commission responsibilities previously combined in one chapter, i.e. Firearms Training and Instructor Training and Certification currently contained in COMAR 12.10.04. By separating the topics, the Correctional Training Commission establishes a distinction between the requirements for firearms classroom instruction, training and qualification, and instructor certification requirements. The current language creates significant overlap between these two topics especially when addressing the various classifications of firearms-related instructor certifications. The proposed action:

(1) Amends references in COMAR 12.10.01 to match changes (deletions and re-codification) to COMAR 12.10.04 and relocation of language in new COMAR 12.10.06;

(2) Amends existing COMAR 12.10.04 by renaming the chapter to Firearms Training and removes instructor training and certification language from the chapter leaving firearms training requirements, with minor formatting updates, as the topic of the chapter;

(3) Deletes the definition of expert from COMAR 12.10.05.01; and

(4) Creates new regulations under COMAR 12.10.06 Instructor Training and Certification using the language, with appropriate formatting updates, removed from existing COMAR 12.10.04.

This action was originally proposed in 38:15 Md. R. 904-922 (July 15, 2011), and re-proposed with significant changes in 38:26 Md. R. 1730-1731 (December 16, 2011). The Commission found it necessary to withdraw (effective March 19, 2012) the proposal for additional review. This action is the result of the Commission's additional review.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Thomas C. Smith, Director, Policy and Process Review, Maryland Police and Correctional Training Commissions, 6852 4th Street, Sykesville, MD 21784, or call 410 875 3605, or email to tcsmith@dpscs.state.md.us. Comments will be accepted through May 21, 2012. A public hearing has not been scheduled.

12.10.01 General Regulations

Authority: Correctional Services Article, §8-208, Annotated Code of Maryland

.04 Selection Standards for Appointment to a Mandated Position and Documentation Requirements.

A. — F. (text unchanged)

G. Drug Screening.

(1) An agency head shall require that an applicant for a mandated position submits to a drug screening to test for controlled dangerous substances, narcotic drugs, and marijuana according to Regulation [.23] *.21* of this chapter.

(2) (text unchanged)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Chairman

Herbert S. Wong, Ph.D.
Vice-Chairman

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TO: Commissioners

FROM: Legal Department

DATE: May 30, 2012

RE: Hearing and Meeting Schedule

Public Session:

July 11, 2012 Time to be Determined, 4160 Patterson Avenue, HSCRC Conference Room

August 1, 2012 Time to be Determined, 4160 Patterson Avenue, HSCRC Conference Room

Please note, Commissioner packets will be available in the Commission's office at 10:00 a.m.

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website.
www.hscrc.state.md.us/commissionMeetingSchedule2012.cfm

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