maryland
health services
cost review commission

Community Benefit Reporting

Guidelines and Standard Definitions

FY 2022

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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 continues 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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Introduction

The term community benefit refers to initiatives, activities, and investments undertaken by tax-exempt hospitals to improve the health of the communities they serve. Maryland law defines community benefit as a planned, organized, and measured activity that is intended to meet identified community health needs within a service area.[1] The Maryland Health Services Cost Review Commission (HSCRC or Commission) is required to collect community benefit information from individual hospitals in Maryland and compile into an annual statewide, publicly available report.

The following guidelines provide instruction and background for the fiscal year (FY) 2022 Community Benefit Report mandated for all Maryland hospitals. The reporting is split into two components, a Financial Report and a Narrative Report. These reports should be completed and reviewed in conjunction with one another, along with supplemental and/or supporting documentation, such as a Community Health Needs Assessment (CHNA) or a Hospital Strategic Plan.

Please note that there are a number of changes to the reporting requirements and definitions, so please read these instructions in their entirety.

Community Health Needs Assessment Community Benefit Spending and Non-Related Spending

The Maryland General Assembly updated §19-303 of the Health General Article in the 2020 Legislative Session (HB1169/SB0774), requiring the HSCRC to update the community benefit reporting guidelines to address the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals in relation to CHNAs.

Section 501(r) of the Internal Revenue Code requires hospital organizations to conduct CHNAs is at least every three years.[2] In addition to general requirements for tax exemption under section 501(c)(3)[3], hospitals must provide facility-by-facility documentation of their CHNA and implementation strategy to meet the needs identified through the CHNA process. Under federal regulation, a hospital facility must complete the following steps in their CHNA process: [4]

1. Define the community it serves.
2. Assess the health needs of that community.
3. In assessing the community's health needs, solicit and take into account input from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health.

[1] MD. CODE. ANN., Health-Gen. § 19-303(a)(3).
[2] 26 USC § 501(r).
[3] 26 USC § 501(c)(3).
[4] 26 CFR § 1.501(r)-3.

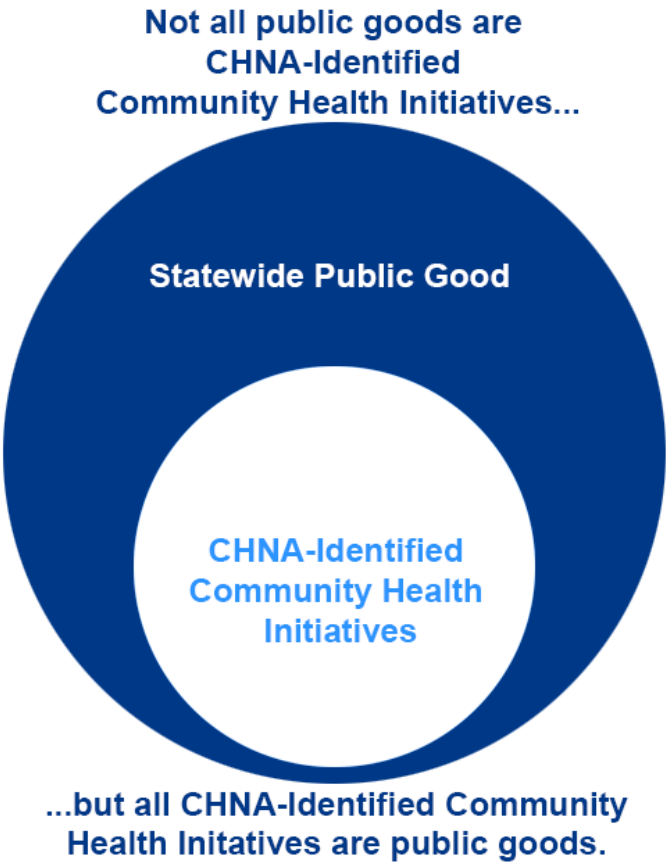
4. Document the CHNA in a written report that is adopted for the hospital facility by an authorized body of the hospital facility.
5. Make the CHNA report widely available to the public.

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

Identifying Community Benefits

Community Benefit includes spending on both statewide public goods and local community health needs identified in a hospital's CHNA, known as Community Health Initiatives. The following descriptions are provided to help hospitals differentiate between their traditional community benefit public goods and the CHNA-related Community Health Initiatives in the new reporting structure moving forward. CHNA priorities/Community Health Initiatives must meet the following criteria:

- Ultimately improve the health status and well-being of the population in the organization's service area
- Focus on improving conditions for those in an organization's service area who are known to have difficulty accessing care and/or who have chronic needs
- Respond to needs of special populations, such as those with health disparities or in poor/declining health status, generating negative margins
- Are not provided for marketing purposes or market share increase
- The service or programs would likely be discontinued if the decision were made on a purely financial basis



Community Benefit Public Goods

A community benefit public good is a planned, organized, and measured approach to providing community benefit and meeting hospital-identified health needs. As described in the figure above, not all community benefit public goods address CHNA-identified needs. For example, hospitals may report pandemic preparedness spending as a community benefit. Although this is obviously a benefit to local communities, it is unlikely to be identified by the community as a health need in non-pandemic years.

To determine whether an initiative is a community benefit public good, 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 CHNA priority?
- Does the activity address at least one of the following community benefit objectives?
    - Improve access
    - Enhance public health
    - Advance increased general knowledge
    - Relieve government burden to improve health

- Does the activity primarily benefit the community rather than the organization?
- Does the activity result in measurable expense to the organization?
- Is the activity provided primarily for marketing purposes?
- Is the activity standard practice expected of all hospitals?
- Is the activity provided primarily for discharged patients?
- Is the activity primarily for employees or affiliated physicians?

Identifying Community Health Initiatives

Community Health Initiatives are line-item programs, activities, or coordinated efforts undertaken by a hospital in response to their CHNA. Hospitals are required to provide a supplemental schedule to the Community Benefit aggregate financial report that identifies line-item Community Health Initiatives that are undertaken in response to their CHNAs.

“Line item,” or individual initiatives can be identified by a number of unique parameters; some or all may apply to Initiatives. In general, hospitals should split eligible Community Health Initiatives into as many distinct line-item initiatives that have one or more of the following distinguishable characteristics:

- A whole or part full-time equivalent (FTE) is dedicated to the work
- A budget is established or funds are allocated to support the Initiative
- Initiative is a line item in a department or hospital budget
- Initiative or work is a component of a department or hospital annual plan/strategy
- Initiative or work is a dedicated effort to target a population, health need, clinical care improvement effort

Priority Areas and Goals

To organize the reporting of CHNA Initiatives, hospitals will be asked to report the corresponding Priority Areas and Goals from their CHNA. Priority Areas organize a myriad of goals, strategies, and data under one unified direction or topic area. The template includes a drop-down menu of Priority Area Categories. Within each Priority Area, hospitals will be asked to outline the Goals that are used to define success or progress on each topic. Goals may be strategies hospitals undertake to impact the Priority Area, targets for the CHNA Priority Area, or specific tasks outlined proposed to address community needs. Goals are typically outlined in the Strategic Planning and Implementation portion of CHNAs, though they may look different across hospitals with varying CHNA structure. Some examples of Priority Areas and Goals are provided below, for further clarification. Please note that this reporting requirement is mandatory FY 2022.

Table 1. Example Approaches by Hospitals to Identifying CHNA Priority Areas and Goals

Hospital A		
CHNA Priority Area	**Goal and/or CHNA Objective**	**CHNA Initiative**
Health Conditions-Mental Health and Drug and Alcohol Use	Mental Health Services and Substance Use Services	- SUD Counseling at local community center - Medication-Assisted Treatment (MAT) Therapy Clinic
Settings and Systems Transportation	Transportation	- Lyft Partnership - Mobile clinics
Social Determinants of Health	Employment	- Job fair - Training program for Support techs
	Housing	- Transitional housing program - Housing Clinics

Financial Reporting

Complete the Community Benefit Financial Report Template provided by the HSCRC using the following guidelines.

To update reporting practices, the HSCRC is implementing a new Financial Template that allows for itemization of programs and initiatives that address community health needs. The Financial Template is broken out into three worksheets. **All three worksheets are required for FY 2022.**

1. The first worksheet, “Community Benefit Overview,” follows the same layout as in prior years, and hospitals are to record total community spending on this worksheet under the allowed categories and subcategory definitions included later in this guidance.
2. In the second worksheet, “CHNA,” hospitals will report on spending related to CHNA initiatives, including the corresponding Priority Areas and Goals from their CHNA. To minimize redundancy with the Narrative Report, this sheet also collects information on data and outcomes. The CHNA initiative description questions have been removed from the Narrative Report.
3. The third worksheet, “Physician Subsidies,” will report detailed physician subsidies by service line.

The final totals in the first worksheet, “Community Benefit Overview” should correspond as closely as possible to the totals submitted to the IRS on Form 990, Schedule H.

Who is Required to Report?

Maryland law requires all nonprofit hospitals to submit an annual community benefit report to the HSCRC.[5] All hospitals reporting an IRS Form 990 Schedule H that do not pay taxes and receive HSCRC rate support must submit a separate community benefit report.

COVID-19 Related Reporting

Hospitals should report pandemic-related community benefit activities in alignment with Schedule H and Generally Accepted Accounting Principles that apply to hospitals. In general, activities performed as part of a billable service, such as COVID-19 testing of patients, should not count as community benefit (unless they qualify as financial assistance or another explicit category in Schedule H). **In order to count COVID-19 activities as a Community Benefit in Maryland, the activity should be focused on community health rather than the hospital's internal functions.** See Attachment A for more detail on COVID-19 reporting.

Financial Accounting

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 hospital services that are reported on the IRS 990 schedule H, and should not include unregulated entities that are not reported on the IRS 990 Schedule H.

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.

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.

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

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 I10. Please enter this number as a whole number, not as a percentage. The spreadsheet will convert the number into a percentage.
4. The HSCRC inventory spreadsheet permits hospitals to calculate indirect cost ratios and enter them 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; (B) Health Professions Education; (C) Mission-Driven Health Services; (D) Research; (F) Community Building Activities; and (G) Community Benefit Operations.
5. Indirect costs may not be reported for categories (E) Cash and In-Kind Contributions and (H) Charity Care.
6. Hospitals should generate separate indirect cost ratios for hospital/facility-based activities and activities based in the community that would have less overhead and lower indirect costs. This "community-based" rate should be lower than the hospital-based rate and should exclude the costs of hospital buildings, the billing office, laundry, and other cost centers that should apply only to hospital-based programs. The Catholic Health Association recommends a 10-15 percent indirect cost rate for community-based programs.
7. For research activities, the hospital should apply any federally-approved rates from the National Institute of Health as applicable.
8. The HSCRC asks that hospitals examine their calculated indirect costs carefully and, when appropriate, 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 that are not accurately represented in the direct costs. However, hospitals should strive to use one of the reported indirect cost ratios to the extent possible.

Offsetting Revenue

Hospitals must report offsetting revenue where applicable. Offsetting revenue is revenue from the activity during the year that offsets the total community benefit expense of that initiative—especially with regards to activities categorized as mission-driven health services. It includes any revenue generated by the activity or program, such as payment or reimbursement for services provided to program patients. This does include restricted grants. It does not include unrestricted grants or contributions that the hospital uses to provide the community benefit.

Hospitals receive rate support for a number of community benefit initiatives, and the HSCRC must account for this in the statewide report. *Hospitals must report all rate-supported initiatives in the Rate Support column*. These include Graduate Medical Education, Nurse Support Programs, and any other restricted grants provided via rate support, including the Regional Partnership Catalyst Grant Program, the Medicare Advantage Partnership Grant Program, the COVID-19 Long-Term Care Partnership Grant, the COVID-19 Community Vaccination Program, and the Population Health Workforce Support for Disadvantaged Areas Program. HSCRC rate support for Charity Care (via the Uncompensated Care adjustment) will remain its own line item. Offsetting revenue provided in the form of HSCRC-approved rates to the hospital should only be reported in the Rate Support column. For items that do not receive Rate Support or that receive additional Rate Support outside of those specific HSCRC Policies, hospitals are expected to report the amount in the Other Offsetting Revenue column.

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.

Accounting Practices and Calculating Costs

The hospital's financial statements most accurately reflect internal accounting practices for tracking community initiatives, 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.

Community Benefit Categories

The Commission has developed this guidance in coordination with federal IRS guidelines, best practices from other states, expert organizations, and those with expertise in community benefits. With this guidance, and within its statutory authority, the HSCRC has specified what may be considered an initiative or program appropriate for inclusion in a hospital's community benefits inventory.

This section provides guidelines on how to count and quantify community benefits, including the Community Health Initiatives break out. Within the Financial Reporting template, hospitals will be required to categorize both CHNA and non-CHNA Initiatives into one of the following categories based on the provided definitions and examples.

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

T00. Medicaid Costs

In FY 2022, Maryland hospitals are required to provide a Deficit Assessment Fee to the Maryland Medicaid Program. Leave this row blank. HSCRC will provide this data.

A00. Community Health Improvement 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 persons with low income should be reported separately as charity care (See section H Charity Care/Financial Assistance).

The table below provides example subcategories with definitions for Community Health Improvement Services. Within each of these example areas, the HSCRC has provided examples of applicable programs.

Subcategory	Definition	Count	Do not Count
Community Health Education	Community health education activities provided to groups, without providing clinical or diagnostic services.	*Community benefit in this area can include staff time, travel, materials, and indirect costs.* • Baby-sitting courses • Staff time writing an article on specific disease conditions or health issue, provided the purpose is not marketing or publication in a journal/peer reviewed publication • Caregiver training for persons caring for family members at home • Community newsletters - if the primary purpose is to educate the community about	*Health education designed to increase market share, eligible for reimbursement, marketing purposed or necessary for patient care.* • Health education activities designed to increase market share (such as prenatal and childbirth programs for private patients) • Prenatal and other educational programs for low income population that is reimbursed • Health education sessions offered for a

Subcategory	Definition	Count	Do not Count
		health programs and free events • Consumer health library • Education on specific disease conditions that is not billable (diabetes, heart disease, etc.) • Health fairs that respond to community health needs • 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 • Staff hours providing information through press releases and other modes to the media • Information provided through news releases and other modes of media to educate the public about health issues • School health education programs • Work site health education programs	fee in which a profit is realized • In-house pastoral education programs • Volunteer time for parish and congregation-based and other services • 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)

Subcategory	Definition	Count	Do not Count
Support Groups	Groups 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.* • Support groups related to community need, such as for prevention of child abuse or managing chronic disease • Costs to run various support groups, (e.g., diseases and disabilities, grief, infertility, patients' families, other)	*Groups to increase market share, reimbursed or given during treatment.* • Support given to patients and families in the course of their inpatient or outpatient encounter. • Childbirth and parenting education classes that are reimbursed or designed to attract paying or insured patients.
Self-Help	Wellness and health promotion programs offered to the community.	*Free services available to improve health and self-management of disease.* • Anger management • Exercise • Mediation programs • Smoking cessation • Stress management • Weight loss and nutrition • Other relevant programs	*Services eligible for reimbursement.* • Billing for Diabetes Prevention Programs • Health care organization employee wellness and health promotion provided as an employee benefit.
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	• Behavioral health screenings • Blood pressure screening • Lipid profile and/or cholesterol screening • Eye examinations • General screening programs or health risk assessments	• Screenings for which a fee is charged, unless there is a negative margin • Screenings where referrals are made only to the health care organization or its physicians

Subcategory	Definition	Count	Do not Count
	activity designed to detect the early onset of illness and disease and can result in a referral to any community medical resource.	• Health risk appraisals • Hearing screenings • Mammography screenings • screenings • School physical examinations • Skin cancer screening • Stroke risk screening • Other non-billable screenings	• Screenings provided primarily for public relations or marketing purposes • Free school team physicals provided for public relations purposes • Mammography screenings conducted separate free-standing breast diagnostic center (then report in C, Mission Driven Health Services)
Community-Based Clinics	Clinical services provided in the community setting, free of charge to promote health actions or provide preventative care.	*This includes one-time or occasionally held clinics in addition to ongoing programs/efforts with negative margins.* • Blood pressure and/or lipid profile/cholesterol • Screening clinics • Cardiology risk factor screening clinics (take care not to include if screening is really marketing or case-finding) • Colon cancer screening clinics • Dental care clinics • Immunization clinics • One time or occasionally held primary care clinics • School physical clinics • Stroke screening clinics	*This category does NOT include subsidized, permanent hospital outpatient services (reported in Mission Driven Services).* • Free school team physicals, unless there is a demonstrated need for this service • Flu shots or physical exams for employees • Clinics for which a fee is charged/billed
Clinics for Underinsured	Clinics that provide free or low-cost health care to medically	*Only include clinics for which physicians and health*	*Do not include services for which the hospital can bill or*

Subcategory	Definition	Count	Do not Count
and Uninsured Persons	underinsured and uninsured persons.	*care professionals donate their time.* • Hospital subsidies such as grants • Costs for in-kind support, equipment, overhead costs • Lab and medication costs	*which costs are offset by fees paid by patients.* • Volunteers' time and contributions by other community partners
Mobile Units	Mobile units that deliver primary, crisis and preventative care to underserved populations on an occasional or one-time basis	*Can be provided on an ongoing, occasional or one-time basis.* • Vans and other mobile units used to deliver primary or preventative care services • Mobile crisis units • Dental Care units	*Subsidized, mobile specialty care services that are an extension of the organization's outpatient department, for example:* • Mobile mammography, radiology, lithotripsy, etc.
Health Care Support Services	Services that increase access and quality of care individuals, especially persons living in poverty and those in other vulnerable populations.	*Free services that help to address social determinants of health that could preclude improved outcomes during care should be counter here.* • Enrollment assistance in public programs, including state, indigent, and Medicaid and Medicare programs information and referral to community services • Resource Hotlines and Telephone information services (Ask a Nurse, medical and mental health service hotlines,	*Do not count service that is expected in a routine course of inpatient or outpatient care and follow-up.* • Physician referral if it is primarily internal to the organization • Support given to patients and families in the course of their inpatient or outpatient encounter • Routine discharge planning

Subcategory	Definition	Count	Do not Count
		poison control centers) • Transportation programs for patients and families to enhance patient access to care, (include cab vouchers provided to low-income patients and families) • Free Medications or medication subsidies/vouchers	

B00. Health Professions Education

As a reminder, Maryland law defines a community benefit as a planned, organized, and measured activity that is intended to meet an identified community health need within a service area.

Additionally, please remember that offsetting revenue provided in the form of HSCRC-approved rates *should* be reported in the "Offsetting Revenue" column.

Subcategory	Definition	Count	Do not Count
Physicians/Medical Students	Training support provided to licensed or pre-licensed physicians.	*Education provided to support physicians, regardless of workplace/end placement.* • A dedicated clinical setting for undergraduate/vocational training • Internships/clerkships/residencies • Residency education not covered by federal funding • Fellows that are paid for by the hospital • Continuing medical education (CME)	*Education required by physician staff and new training as a part of the organization's mission.* • Expenses for physician and medical student in-service training Joint appointments with educational institutions, medical schools • Orientation programs • Continuing medical education (CME) costs to members of the medical staff

Subcategory	Definition	Count	Do not Count
		offered to physicians outside the medical staff on subjects for which the organization has special expertise	
Nurses/Nursing Students	Training support provided to licensed or pre-licensed nurses and nurse practitioners.	*Education provided to support nurses, regardless of workplace/end placement.* • The provision of a clinical setting for undergraduate/vocational training to students enrolled in an outside organization (count time that staff nurses are taken away from their routine duties) • Internships/externships when on-site training of nurses (e.g., LVN, LPN) is subsidized by the health care organization • Costs associated with underwriting faculty positions in schools of nursing in response to shortages of nurses and nursing faculty	*Education required by nursing staff, such as orientation, in-service programs, and new graduate training.* • Expenses for standard in-service training and in-house mentoring programs • In-house nursing and nurse's aide training programs • Programs where nurses are required to work for the organization • Staff costs associated with joint appointments with educational institutions, nursing schools
Other Health Professionals	Training support provided to licensed or pre-licensed professionals and other non-licensed healthcare professionals.	*Education not required of staff and provided to all, regardless of workplace/end placement.* • A clinical setting for undergraduate training and internships for dietary professionals, technicians, chaplaincy/pastoral care,	*Education <u>required</u> by staff, such as orientation, in-service programs or provided to increase workforce capacity.* • Expenses for standard in-service training • On the job training, such as pharmacy technician and nurses assistant programs

Subcategory	Definition	Count	Do not Count
		physical therapists, social workers, pharmacists, and other health professionals • Training of health professionals in special settings, such as occupational health or outpatient facilities • Unpaid costs of medical translator training beyond what is mandated • Medical libraries open to the general public	• Programs where trainees are required to work for the organization
Scholarships/ Funding for Professional Education	Direct assistance provided to staff, trainees or students to advance the clinical mission of the hospital.	*Funding intended to advance or improve the institution's community and staff unassociated with the institution.* • Funding, including registrations, fees, travel, and incidental expenses for staff education that is linked to community services and community health improvement • Scholarships or tuition payments for nursing and health professional education to nonemployees with no requirement to work for the organization as a condition of the scholarship • Specialty in-service and videoconferenci	*Funding intended to advance or improve the institution's staff and clinical care.* • Costs for staff conferences and travel other than those listed above • Financial assistance for employees who are advancing their own educational credentials • Staff tuition reimbursement costs provided as an employee benefit • Financial assistance where students/trainees are required to work for the organization

Subcategory	Definition	Count	Do not Count
		ng programs made available to professionals in the community	

C00. 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 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.

Hospitals must take care to ascertain whether the negative contribution is truly a community benefit. The HSCRC reiterates that those initiatives geared toward increasing a hospital's market share or 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 a planned, organized, and measured activity that is intended to meet identified community health need within a service area." Please also refer to pages 3-4 of these guidelines to the checklist of questions developed by VHA and CHA to help determine whether an activity is appropriately considered a community benefit.

Physician Subsidies

As required under HG §19-303, hospitals are required to provide details of specialist physician availability in their service area.

- *Hospitals are required to report all subsidies as a single line item under section C*—Mission Driven Health Services—within the main financial spreadsheet. Report this in row C10.
- The remainder of section C is where hospitals should report all other mission-driven health services, not including any physician subsidies.

Sheet 3, "Physician Subsidies" is where hospitals must itemize each physician subsidy and provide detailed accounting. 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. Per HG §19-303, hospitals are required to list whether there is a gap in physician availability. Information on these gaps is collected in the narrative report, and detailed instructions are provided in the narrative report section of this document.

In the Physician Subsidies tab, hospitals must classify physician subsidies for each physician specialty type into the following categories:

- Non-resident house staff and hospitalists
- Coverage of Emergency Department call
- Physician provision of financial assistance to encourage alignment with hospital financial assistance policies
- Recruitment of physicians to meet community need as shown by a hospital's medical staff development plan

Other costs as appropriate can only be included if supplemental documentation describing the service and community need being met is provided. Hospitals should not report "other" physician subsidies, they must itemize by the specialty and group of physicians subsidized. Also to the degree possible, categorize physician staffing of community-based clinics that serve underserved populations or otherwise meet unmet community need under section A, Community Health Services.

Subcategory	Definition	Count	Do not Count
Mission Driven Health Services	Services a hospital undertakes as a direct result of its community's need or a gap in the community that would not be provided without the hospital.	*Services undertaken as a direct result of the hospital's mission or position in the community.* • Organizationally owned health care clinics or urgent care centers • Hospice services • Outpatient mental health services	*Services provided as a routine cost of business, to increase a hospital's market share or that operate at a loss.* • Bad Debt • Hospital-based charity care • Costs of physician contracts that are part of routine hospital business and are not associated with addressing a specific need or gap in the community

D00. Research

Subcategory	Definition	Count	Do not Count
Clinical Research	Research that determines the safety and efficacy of medications, devices, diagnostic products and treatment regimens intended for human use.	*Research used for prevention, treatment, diagnosis or for relieving symptoms of a disease both in the hospital and medical community at large. Count the difference between operating costs and external*	*Research intended to increase market share, provide hospital marketing, and/or develop patents or profitable revenue streams.* Research where findings are only used internally

Subcategory	Definition	Count	Do not Count
		subsidies such as grants (negative margin). • Unreimbursed studies on therapeutic protocols • Evaluation of innovative treatments • Research papers prepared by staff for professional journals	
Community and Health Services Research	Multidisciplinary investigation studying how social factors, financing systems, organizational structures and processes, health technologies, and personal behaviors affect access to health care, the quality and cost of health care, and patient well-being. CHNA preparation activity should be reported in the Community Benefit Operations category.	*Research directed towards the hospital's community needs and those of the health system. Count the difference between operating costs and external subsidies such as grants (negative margin).* • Studies on health issues for vulnerable persons • Studies on health issues for racial and ethnic minority groups • Studies on community health, incidence rates of conditions for special populations • Research papers prepared by staff for professional journals or presentation • Research studies on innovative health care delivery models	*Research intended to increase market share, provide hospital marketing, and/or profitable revenue streams.* Research where findings are only used internally

E00. Cash and In-Kind Contributions

Subcategory	Definition	Count	Do not Count
Cash Donations	Money contributed by check, credit card, electronic funds transfer, or payroll deduction	*Only count funds allocated to Community Benefits, as is reported on the IRS 990 Schedule H.*	*Funds donated on behalf of the institution should not be counted, nor should fees associated with donation.*

Subcategory	Definition	Count	Do not Count
	to organizations outside of the hospital.	• 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	• Employee-donated funds • Emergency funds provided to employees • Fees for sporting event tickets
Grants	A financial award given by the hospital or parent institution to some external organization to fund a beneficial project.	*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	*Contributions as a part of the organization's mission as an academic or research institution to internal and external research partners should not be counted.*

Subcategory	Definition	Count	Do not Count
In-Kind Donations	Provision of goods and services free of cost to community partners and needs.	*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.* • 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	*In-kind donations made on behalf of the institution or in affiliation should not be counted.* • 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 • 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.

Subcategory	Definition	Count	Do not Count
		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.	
Cost of Fund-Raising for Community Programs	Costs of raising funds for community benefit and health programs.	*Grant writing and other fund-raising costs specific to community benefit programs and resource development assistance not captured under category G., Community Benefit Operations*	*Fundraising costs for the hospital should not be counted.*

F00. Community Building Activities

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. When funds or donations are given directly to another organization, count in E. Donations.

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

Subcategory	Definition	Count	Do not Count
Physical Improvements and Housing	Efforts made to improve access in the community to safe, healthy, and improved permanent housing.	*Direct support made to community-based efforts, such as:* • 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	*Subsidies or grants included in the total expense/budget of the initiative spending. Additionally, do not count initiatives that only directly impact or improve the hospital community. Including:* • Housing costs for employees or contractual employees • Projects having their own community benefit reporting process: e.g., a senior housing program that issues a community benefit report • Health facility construction and improvements, such as a meditation garden or parking lot.
Economic Development	Initiatives that focus on improving economic conditions in the community and providing investment or advisory support to attain future improvement.	*Direct support made to community-based efforts, such as:* • Small business development • Participation in economic development council, chamber of commerce • Economic development council, chamber of commerce	*Subsidies or grants included in the total expense/budget of the initiative spending. Additionally, do not count initiatives that only directly impact or improve the hospital community. Including:* • Routine financial investments

Subcategory	Definition	Count	Do not Count
Community Support	Initiatives intended to provide the community with unique support to bolster preparedness and development efforts that would not otherwise exist without the hospital.	*Direct support made to community-based efforts, such as:* • Adopt-a-school efforts • Child care for community residents with qualified need • Mentoring programs • Neighborhood groups • Youth Asset Development initiatives, including categories of caring adults, safe places, healthy start, marketable skills, and opportunities to serve • Mental health resource costs associated with training, community partnerships, and outreach planning	*Subsidies or grants included in the total expense/budget of the initiative spending.* *Additionally, do not count initiatives that only directly impact or improve the hospital community. Including:* • Costs associated with subsidizing salaries of employees deployed in military action (this is considered employee benefit)

Subcategory	Definition	Count	Do not Count
Environmental Improvements	Initiatives focused on responding to or preventing environmental deterioration that may adversely affect health.	*Direct support made to community-based efforts, such as:* • 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 green purchasing and other waste/mercury reduction initiations	*Subsidies or grants included in the total expense/budget of the initiative spending.* *Additionally, do not count initiatives that only directly impact or improve the hospital community.*
Leadership Development/ Training for Community Members	Initiatives provided to develop community member skills, leadership and empowerment.	*Direct support made to community-based efforts, such as:* • Conflict resolution • Community leadership development • Cultural skills training • Language skills/development	*Subsidies or grants included in the total expense/budget of the initiative spending.* *Additionally, do not count initiatives that only directly impact or improve the hospital community. Including:* • Interpreter training programs for hospital staff, as required by law

Subcategory	Definition	Count	Do not Count
		• Life/civic skills training programs • Medical interpreter training for community members	
Coalition Building	Efforts to partner with and support community groups and community-wide, representative collaboration.	*Direct support made to community-based efforts, such as:* • 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	*Subsidies or grants included in the total expense/budget of the initiative spending. Additionally, do not count initiatives that only directly impact or improve the hospital community.*

Advocacy for Community Health Improvements	Initiatives that aim to bring awareness and investment into key community health areas that respond to emergent needs.	*Direct support made to community-based efforts, such as:*
		• 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
			Subsidies or grants included in the total expense/budget of the initiative spending. Additionally, do not count initiatives that only directly impact or improve the hospital community. Including:
			• Advocacy specific to hospital operations/financing

Subcategory	Definition	Count	Do not Count
Workforce Development	Initiatives provided to develop and promote community member skills to engage in the local workforce.	*Direct support made to community-based efforts, such as:* • 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	*Subsidies or grants included in the total expense/budget of the initiative spending.* *Additionally, do not count initiatives that only directly impact or improve the hospital community. Including:* • 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

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.

Subcategory	Definition	Count	Do not Count
Assigned Staff	Staff assigned to develop community benefit reporting and coordinate Community Benefit Initiatives.	• 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	• Staff time to coordinate in-house volunteer programs, including outpatient volunteer programs • Volunteer time of individuals for community benefit volunteer programs
Community Health Needs Assessment	Staff and efforts around the required Community Health Needs Assessment.	• Community health needs assessment staff and report development • Community assessments and external data acquisition for the CHNA • Costs related to developing the implementation strategy	• Costs of a market-share assessment and marketing survey process • Economic impact survey costs or results • Marketing surveys
Other		• 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 benefits	• 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

Subcategory	Definition	Count	Do not Count
		• 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	

H99. Charity Care/Financial Assistance

Charity care is:

- Free or discounted health and health-related services provided in accordance with the hospital's financial assistance policy as defined in Health-General §19-214.1 and in the accompanying regulations
- 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

I10. Indirect Costs

Report the hospital's indirect cost ratios here, as described on pages 6-7 above.

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.

Narrative Reporting

In addition to the inventory spreadsheet that collects financial and quantitative information described above, the Commission also collects a narrative report to strengthen and supplement the inventory spreadsheet. The narrative guidelines were developed in accordance with the requirements of §19-303 of the Health General Article, which was amended during the 2020 Legislative Session (HB1169/SB0774), requiring the HSCRC to address the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals in relation to CHNAs and to collect a list of tax exemptions claimed by each hospital. The narrative report has six sections: (1) the general demographics of the hospital community, (2) how the hospital developed the CHNA priority areas with the communities they serve, (3) community benefit administration, (4) physician subsidies and shortages funded through the Mission Driven Services category, (5) Financial Assistance Policy (FAP) provision, and (6) a list of tax exemptions claimed by the hospital.

Responses to each question are mandatory unless otherwise specified as optional. Hospitals are expected to respond to any follow-up/clarifying questions from staff to ensure completeness and accuracy of the report.

The Commission moved to an online reporting format beginning with the FY 2018 reports. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users. For technical assistance with the reporting system, contact HCBHelp@hilltop.umbc.edu.

Section 1. General Demographics

This section of the narrative report remains largely the same as in prior years. In this section, hospitals are required to report on:

- Community health statistics that the hospital uses in community benefit efforts
- The zip codes that make up the hospital's community benefit service area (CBSA), which refers to the area where your hospital directs its community benefit efforts
- The method(s) by which the identifies its CBSA
- The hospital's mission statement

Section 2. CHNAs and Stakeholder Involvement

This section requires hospitals to report on CHNA-related activities.

Questions 1-4 in this section ask hospitals to report on the timing of their CHNAs and to provide their CHNA documents.

Questions 5-6 require hospitals to report on the internal and external stakeholders involved in the CHNA process. Community participation and meaningful engagement is an essential component to changing health system behavior, activating partnerships that improve health outcomes and sustaining community ownership and investment in programs. In an effort to gauge and potentially implement improvements to the public engagement process of CHNAs, the HSCRC uses an evidence-based scale to measure hospital efforts in this area.

Hospitals are asked to describe internal and external engagement while creating their CHNA and Community Benefit Reporting. HSCRC staff developed this question based upon the International Association for Public Participation's (IAP2) "Spectrum of Public Participation" by supplementing

additional details from research and literature reviews. The narrative report will ask hospitals to rate the level of engagement each participant based on the table below based on a description and set of process measures for each level. Hospitals will be asked to identify categories of community participants involved in the CHNA process. **Note: this self-assessment is mandatory for FY 2022.** For each category, hospitals will rank the following:

1. Informed	2. Consulted	3. Involved	4. Collaborated	5. Delegated	6. Community-Driven/ led
To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	To obtain community feedback on analysis, alternatives and/or solutions	To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	To place the decision-making in the hands of the community	To support the actions of community initiated, driven and/or led processes
We will keep you informed	We will keep you informed, listen to & acknowledge concerns, aspirations, & provide feedback on how community input influenced decisions	We will work with you to ensure that your concerns & aspirations are directly reflected in the alternatives developed and provide feedback on how that input influence decisions	We will look to you for advice & innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible	We will implement what you decide, or follow your lead generally on the way forward	We will provide the needed support to see your ideas succeed
- Fact Sheets - Web sites - Open Houses	-Public comments - Focus groups - Surveys - Community meetings	-Workshops - Deliberative polling - Advisory bodies	- Advisory groups - Consensus building - Participatory decision making	- Advisor bodies - Volunteers/stipends - Ballots -Delegated decision	- Community supported processes - Advisory bodies - Stipend roles for community - Funding for community

The Maryland Hospital Association also worked with the HSCRC to develop eight recommended practices for engaging patients and communities in the CHNA process. Hospitals will be asked to

indicate whether they are currently using each recommended practice. Hospitals will be asked to describe how they are currently meeting or intend to meet each practice. The following are the recommended practices. Each of these items should be considered within the context of hospital resources, infrastructure to complete the CHNA and implementation plan, geography served, and other internal factors. These are not meant to be minimal thresholds.

Step 1: Identify and Engage Stakeholders

- CHNAs collaborate with other hospitals and local health departments.

  Hospitals should consider collaborating with other hospitals and other organizations in conducting their CHNAs, when possible, to the extent they serve the same communities.

- Consider other community sectors for partnership in the CHNA process: agriculture/food suppliers; employers; culture/arts; education; environment; government; health care; housing and economic development; human services; law enforcement; media; philanthropic organizations; religion; service/fraternal organizations; sports and recreation; volunteers and activists; vulnerable populations; and youth.

- Engage stakeholders inside the hospital and health system. Increasing engagement in this way can encourage integration of prioritized community health needs into operations.

Consider engaging clinicians, particularly from the primary care setting, or specialty clinicians whose focus aligns with community health needs (e.g., behavioral health professionals, nutritionists).

Consider patients and their family members as key stakeholders in the CHNA process. Though they may be considered community members, their experiences in the health care system give them a different perspective on the community's health needs. Individuals involved in patient and family advisory councils (PFACs) may be enthusiastic about contributing to the CHNA process.

- Collect community input using one or more of the following methods: community forums, focus groups, interviews, and/or surveys

  Consider opportunities to engage existing community groups by using their data, reports, recommendations to inform the CHNA. Participation on community boards, workgroups, and commissions will facilitate a stronger understanding of their perspectives.

Step 2: Define the Community to be Assessed

- Determine the scope of your "community."
- Consider how other organizations, such as the local health department, define the community.

  While the geographic hospital service area that includes the greatest percentage of discharges may be one way to define "community" for purposes of the CHNA, it may be a *starting point* for assessing health needs. The community examined may differ from the general patient care population. Consider all of the relevant facts and circumstances, including the geographic area served by the hospital.

  Potential ways to examine: target population served and whether there are populations within the service area with specific unmet health needs.

Step 3: Collect and Analyze Data

- To the extent practicable, collect and analyze data on race, ethnicity, language preference, income, disability status, veteran status, sexual orientation, and gender or gender identification to better understand the community in which the hospital serves.
- Aim to collect opinions and priorities from diverse segments of the population.
- Collect data on social determinants of health, including subpopulation disparities. Aggregate data can tell a story about the community without accounting for elevated rates of a health issue among one particular population or geographic area.

  Identifying health disparities is a critical component of assessing community health needs. Wherever possible, include data stratified by vulnerable groups or populations in its CHNA to identify and monitor health disparities.

- Some segments of the population may not be well represented in existing data; use targeted efforts to engage individuals from those populations and organizations serving those populations in the CHNA process.
- Use qualitative, and quantitative, data to capture a broader, nuanced understanding of issues.

Step 4: Select Priority Community Health Issues

- Document the prioritization process, including what factors were considered most important and how the decisions were made.

Step 5: Document and Communicate Results

- Share the CHNA and corresponding implementation strategy with all partners and contributors to the extent practicable.

  Consider opportunities to engage community members and patients who were involved in the CHNA process to serve as community ambassadors to talk about the assessment outcomes.

  To the extent practicable, post the report before it is final and solicit comments. Once finalized, continue to solicit comments to inform future implementation strategies.

Step 6: Plan Implementation Strategies

- Implementation strategy should be reviewed annually and updated as needed to include the specific programs or activities the hospital intends to undertake, including any planned collaborations with other organizations.
- The updated implementation strategy should be made publicly available by posting on hospital website and in other ways.

Step 7: Implement Improvement Plans

- Determine a strategy to engage the community on an ongoing basis.

Step 8: Evaluate Progress

- For evaluation from the start of the CHNA process.
- To the extent practicable, determine measurable goals and metrics for implementation strategies. Periodically evaluate measure and metrics and update as appropriate.

Question 7 asks hospitals about their CHNA implementation strategies.

Questions 8-9 are optional and allow hospitals to provide additional information or documents related to their CHNAs.

Questions 10-12 ask about CHNA needs not addressed by the hospital's community benefit initiatives, as well as efforts to track and reduce health disparities.

Question 13 asks hospitals to describe HSCRC rate support claimed in the financial report (described in the off-setting revenue section above).

Section 3. Community Benefit Administration

This section asks questions about how the hospital administers its community benefit programming. Questions 1-5 ask about auditing and Board approval of community benefits, as well as the extent to which community benefits are included in the hospital's strategic plan.

Questions 6-7 ask about how the hospital's community benefit activities align with state health goals, particularly the Statewide Health Improvement Strategy (SIHIS). More information about SIHIS may be found here: https://hscrc.maryland.gov/Documents/Modernization/SIHIS%20Proposal%20-%20CMMI%20Submission%2012142020.pdf

Section 4. Physician Subsidies and Gaps

This section of the narrative report must tie to each line-item physician subsidy reported in Worksheet 3 of the financial report.

As required under HG§19-303, question 1 requires the hospital to list all gaps in physician availability resulting in a subsidy reported Worksheet 3 of the financial report. For each gap listed, question 2 requires the hospital to select the type of physician subsidy:

a. Non-resident house staff and hospitalists
b. Coverage of emergency department call
c. Physician recruitment to meet community need
d. Physician provision of financial assistance

Question 3 requires the hospital to provide a detailed explanation as to how the services would not otherwise be available to meet patient demand and why each subsidy was needed. Include relevant data and upload any corresponding documents to justify the subsidy.

Section 5. Financial Assistance Policies

This section requires hospitals to report on their financial assistance policies (FAPs) in accordance with Health-General §19-214.1(e).

Questions 1-2 require hospitals to upload copies of and provide links to their FAPs.

Question 3 asks hospitals to describe any changes to their FAPS within the past year.

Questions 4-6 require hospitals to report on the income criteria for their FAPs for the following:

- Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL). Report the percentage of FPL below which your hospital's FAP offers free care.
- Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level. Report the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care.
- Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health General §19-214.1(a)(2) and COMAR

10.37.10.26(A-2)(1)(b)(i) as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

a. Report he range of the percentage of FPL for which your hospital's FAP offers reduced-cost care for financial hardship.
b. Report he threshold for medical debt as a percentage of family income above which qualifies as a financial hardship.

Section 6. List of Tax Exemptions

Health General Article §19-303 (c)(4)(ix) newly requires the HSCRC to collect "a list of the tax exemptions the hospital claimed during the immediately preceding taxable year." This section requires hospitals to list their tax exemptions. Please note that there is no community benefit spending threshold in Maryland or federal law.

- Federal corporate income tax
- State corporate income tax
- State sales tax
- Local property tax (real and personal)
- Other (describe)

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