Maryland Hospital Community Benefit Report
FY 2005

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Maryland Hospital Community Benefit Report
(Fiscal Year 2005)

Introduction

Under the Health General Article §19-303 Maryland Annotated Code, the Health Services Cost Review Commission ("Commission" or "HSCRC") is responsible for collecting hospital community benefit information from individual hospitals to compile into a publicly-available statewide Community Benefit Report (CBR). This larger statewide document contains summary information for all submitting Maryland hospitals; individual hospital community benefit reports and additional documents are available in written form at the Commission's offices. Individual community benefit report data spreadsheets will be available on the Commission's website in September 2006.

While many Maryland hospitals and health systems already prepare a report to the community describing the services and benefits they provide, there were no statewide guidelines outlining what information is collected until the passage of the Maryland Community Benefit Report requirements. Use of the guidelines permits hospitals and health systems to:

- Present a comprehensive picture of the organization's community benefits;
- Share models of successful community benefit activities;
- Participate in a statewide report on community benefits; and
- Strengthen grant applications and other funding requests.

The community benefit report is an opportunity for each Maryland hospital to critically examine, evaluate, and report the nature, impact, long term sustainability, and success of those activities. The HSCRC has viewed the CBR as a work-in-progress, in part to its start-up nature in first years, but evolving in future years to both keep pace with the changing environment of community benefits and to improve the report's effectiveness as a public policy tool. Given other states' and organizations experience, it is expected that Maryland's initiative will take several years to mature. For the Commission's second community benefit report, Maryland hospitals and the Commission worked collaboratively with one another and many interested parties, including local health departments and other State and national organizations. The HSCRC commits to continuing this work to further improve the report and to refine definitions as needed.

What are Community Benefits?

As defined under current Maryland law, community benefit means 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 this report, Maryland hospitals provide a broad range of health services to meet

the needs of their communities, often receiving partial or no compensation. Only those programs that result in a financial loss are considered reportable in the data submitted by Maryland hospitals to the HSCRC for this report. These activities are expected from Maryland's 46 not-for-profit hospitals, however, as a result of the tax exemptions they receive[1].

CBR - 2005 Highlights

For FY 2005, Maryland hospitals reported providing a total of over $ 655 million in benefits to their communities. Of this, $255 million was provided in health professionals education activities, nearly $195 million in charity care, over $120 million for mission driven health services, $45 million in community health services, $13 million in financial contributions, $11 million in community building efforts, $5.6 million in foundation community benefit initiatives, $6 million in research efforts, and $3 million in community benefit operations.[2]

Community Benefit Category	Number of Staff Hours	Number of Encounters	Net Community Benefit
Community Health Services	639,332	4,925,491	$45,437,118
Health Professions Education	4,576,338	1,178,512	$255,118,494
Mission Driven Health Services	1,188,995	540,345	$120,647,698
Research	60,086	24,569	$6,463,050
Financial Contributions	28,422	198,825	$13,112,273
Community Building	115,599	54,796	$11,109,868
Charity Care	n/a	n/a	$194,734,509
Foundation	23,606	610,178	$5,678,755
Community Benefit Operations	50,393	70,223	$3,407,408
Total	**6,682,771**	**7,602,939**	**$655,709,174**

For additional detail, please see the chart under Attachment I - Aggregated Hospital CBR Data. For technical definitions of each community benefit category and additional examples of the types of services found within a community benefit category, please see Attachment III - Description and Overview of CBR Data Inventory Worksheet.

Background for Maryland Initiative

The Commission worked with the Maryland Hospital Association and interested hospitals, local health departments, and health policy organizations and associations on the original details and format and updates to the community benefit report since 2003. As the first Community Benefit Report reporting period contained information from Fiscal Year 2004, the

1 As Maryland's only for-profit hospital, Southern Maryland Hospital is not required to submit a community benefit report under the law. Southern Maryland did, however, submit a community benefit report for FY 2005 to the HSCRC, which has been included in this report.

2 These totals include hospital reported indirect costs, which vary by hospital from a fixed reported dollar amount to a calculated percentage of the hospital's reported direct costs.

Fiscal Year 2005 report represents the HSCRC's second effort to accurately capture Maryland Hospital Community Benefit data.

The reporting period for this Community Benefit Report is July 1, 2004 - June 30, 2005. Hospitals submitted their individual community benefit reports by January 1, 2006 to the HSCRC, using audited financial statements as the source for calculating costs in each of the care categories.

The Maryland data reporting spreadsheet and instructions draw heavily on the VHA community benefits initiative, which offers ten-plus years of voluntary hospital community benefit reporting experience across many states and individual community benefit reporting efforts. The VHA developed a standardized approach to community benefit definitions and reporting practices, which was then tailored with help from VHA, Catholic Health Association (which also has many years of national community benefit reporting experience), the Maryland Hospital Association, and participating members of the Community Benefit Workgroup to fit Maryland's unique regulated environment.

Maryland had to make special accommodations to reflect the benefits of hospital rate setting on community benefits. In other states, the majority of hospital community benefits are reported in three areas - shortfalls from governmental payers, charity care, and medical education costs. In Maryland, however, the HSCRC rate setting system builds the costs of uncompensated care (both charity care and bad debt) and teaching for graduate medical education into the rates hospitals are reimbursed, and all payers (including Medicare and Medicaid) pay the same rates for hospital care. To this end, the HSCRC provides data in this report on the revenue provided for the Nurse Support Program, uncompensated care, and graduate medical education, which are funded through hospital rates by all payers (see Attachment IV). In their individual community benefit reports, hospitals were asked not to include revenue provided from hospitals rates as offsetting revenue. While it would be impossible for the HSCRC to provide a one-for-one match with the data reported by hospitals in the individual CBRs, the Commission believed it was necessary for readers to understand that Maryland hospitals receive offsetting revenue through hospital rates for programs identified within the individual community benefit reports.

Changes to Community Benefit Reporting: FY 2004 to FY 2005

As described earlier, the HSCRC's FY 2004 guidelines were based largely on the VHA Community Benefits reporting initiative from the late 1990s, modified in early 2000. As hospitals and policymakers expressed during Maryland's first collection process, the VHA was very aware of the many outstanding questions, overlapping categories, and unclear determinations that occurred when community benefits staff would attempt to appropriately categorize and allocate community benefits initiatives and programs under the older Community Benefit guidelines. They found that "different organizations and people within organizations (used) different definitions of community benefits and have a different understanding of 'what counts.'"

During 2003 and 2004, VHA collaborated with the Catholic Health Association and Lyon Software to review and revise existing community benefit definitions, categories, and reporting guidelines to create a "common national framework for all not-for-profit health care organizations." The Standard Community Benefit Reporting Guidelines and Standard

Definitions were issued in April 2004 to be more helpful, more instructive in terms of "what to count" and "what not to count," offer new categories to recognize the changing landscape of community benefits, and to assist organizations in tracking performance from year-to-year and among health care organizations. At that time, the HSCRC feared issuing new guidelines for comment in the middle of the first year's data collection effort would add confusion and difficulties to the newly implemented process, and so the Commission chose to wait until the first collection period had ended.

For the FY 2005 data collection effort, however, the HSCRC aligned Maryland's FY 2005 Community Benefit Guidelines to track the important and useful national changes. While the Commission realizes that data collection varies from hospital to hospital, the Commission adopted the VHA, CHA, and Lyon software changes, modified (as before) to meet Maryland's unique regulated environment for several reasons.

The reasons for such change were numerous. First, the new national guidelines offer a vetted and standardized approach to community benefits reporting developed after more than a year of collaboration among a diverse group of national health care organizations. The improved guidelines also permit Maryland hospitals the ability to continue to track their performance to external health care organizations. Second, tracking national changes will again place Maryland at the forefront of public reporting and accountability, an important feature as groups continue to challenge whether or not not-for-profit health care organizations deserve continued tax exemption status. Third, new categories and subcategories allow for additional detail in items considered "countable" and offer more advice on items not considered "countable."

As a result of these changes, several differences exist between the FY 2004 and FY 2005 hospital community benefit reports of which readers should be aware.

Indirect Costs

During FY 2005, hospitals were permitted two options within the indirect cost column. The first is unchanged from FY 04 – the ability to allow the spreadsheet to calculate a standard indirect cost amount by community benefit category (based on the number entered under spreadsheet Item I1, calculated from the hospitals financial data).

In FY 2005, hospitals also had the ability to enter a specific dollar amount in the indirect cost column for a particular community benefit initiative or program if it believes the spreadsheet number is unreasonable or if it believes direct costs are already contained within the hospital's reported direct costs. This enabled hospitals to distinguish indirect costs by community benefit initiative on the spreadsheet.

Community Health Services

The major change for Community Health Services is that many areas from the FY 2004 report were collapsed and streamlined into this broader, more inclusive category. Details include:

- *A1. Community Health Education*
  - Includes FY 2004 examples and adds support groups (A3 from FY 04) & self-help (A5 from FY 04).
- *A2. Community Based Clinical Screenings* (Screenings from FY 04)
  - Continues to include screenings and adds:

        - One-time or occasionally held clinics
        - Free clinics (formerly A7 from FY 04 – HSCRC has kept distinction between organizationally owned clinics and non-healthcare organization sponsored clinics)
        - Mobile units (formerly seen under A8 Other from FY 04)
- *A3. Health Care Support Services* (similar to A4 Counseling from FY 04)
    - Continues to be services given on a one-to-one basis. Does pull programs from other areas:
        - Enrollment assistance in Medicaid/Medicare
        - Information and referral to community services
        - Transportation programs (formerly A8 Other from FY 04)
        - Ask a Nurse and other health care call lines (formerly A1 from FY 04)
- *A4. Other*
    - Since many Community Service programs were collapsed into A1-A3 above, Other can now be A4 (formerly A8 from FY 04)

Health Professions Education (Medical Education in FY 2004)

This community benefit reporting section was largely kept the same; new definitions and things considered "countable" were added.

Mission Driven Health Services (both Mission Driven Health Services and Grey Areas in FY 2004)

The HSCRC eliminated the "Gray Areas" category (Section G from FY 04) and instead asked hospitals to report all Mission Driven Health Care Services under one section. The Commission also asked hospitals that reported physician subsidies to provide additional detail and descriptions of those subsidies.

Research

Additional subcategories with further specific detail were added for the FY 2005 report (Research in FY 04 had no subcategories).

Financial Contributions ("Donations" from FY 2004)

This community benefit category was renamed and slightly broadened for the FY 2005 report:

- E1 Cash (same as FY 04)
- E2 Grants (formerly In-kind Donations from FY 04)
- E3 In-kind (formerly E2 from FY 04 – also moved Meals on Wheels here from A8 Other from FY 04).
- E4 Cost of Fund Raising for Community Programs

Community Building

This community benefit category was a reworking of the existing community building category from FY 2004, with the added creation of new subcategories to further delineate hospital initiatives:

- F1 Physical Improvements/Housing (Housing formerly under F2 Economic Development from FY 04)
- F2-F3 same (moves Housing to F1 and collapses former F5 Disaster Preparedness from FY 04 to within F3)

- F4 Environmental Improvement (new)
- F5 Leadership Development/Training for Community Members (largely F4 Leadership Development & Skills Training from FY 04, but adds Community Member Training component)
- F6 Coalition Building (new)
- F7 Community Health Improvement Advocacy (new)
- F8 Workforce Enhancement (new)

Community Benefits Operations (New for FY 2005)

This community benefit category was created to allow for the collection of costs associated with dedicated community benefits staff, needs assessment and evaluation costs, and any other additional resources used to collect community benefits information.

Issues

The standardized reporting format for community benefits will not result in identical reports from Maryland hospitals. As most hospitals address community needs in the most appropriate manner and setting, reporting of the community benefit may not be allocated in exactly the same category or result in the same amount of reportable costs. For example, one hospital may conduct childhood immunizations at its local Head Start facility, while another hospital may find that an on-campus hospital facility is more centrally located to the community.

Physician Subsidization Costs

As described earlier, many hospitals identified broad physician subsidy costs in the FY 2004 community benefit reports. These subsidies varied by hospital service (obstetrics, pediatrics, psychiatric, neonatal, emergency, and anesthesiology) and by type (on call, charity care provided by facility-owned physician groups, and general subsidy costs). For FY 2004, hospitals reported over $37 million in physician subsidies in their community benefit reports.

Based on this experience, during the FY 2005 community benefit reporting period, the Commission asked hospitals to include more detail describing the nature of these physician subsidies. Specifically, hospitals that were considering reporting physician subsidies as a community benefit were asked 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. Hospitals specifically designated those costs attributable in a separate line distinct from other mission driven health services within Section C, Mission Driven Health Services. Hospitals were also asked to include the necessary detail to explain to the reader of the hospital's community benefit report the nature and details of the physician subsidy. Finally, hospitals were reminded to include only items that generate a negative margin and that have not been otherwise accounted for in a separate Community Benefit reporting section

For FY 2005, hospitals reported over $53 million in physician subsidies, which includes the hospital services and types described above, with the addition of physician recruitment costs. Unfortunately, many of the individual 2005 reports did not contain sufficient detail for the Commission to assess when these subsidies are correctly allocated as community benefits. As a result, the Commission will make the inclusion of the physician subsidy detail a requirement of the FY 2006 Maryland Hospital Community Benefit Reports.

The Commission, hospitals, and interested parties will continue to explore the subject of

physician subsidies, with the hope that the greater use of locally directed community needs assessments will assist hospitals in determining when these subsidies are allocated correctly.

For more detailed information regarding individual hospital physician subsidies, the HSCRC would direct readers to the individual hospital community benefit report and hospital contact of interest.

Indirect Cost Ratio

Hospitals report the direct costs of offering specific community benefits initiatives in their CBR inventory worksheet. To eliminate the probability that hospitals would uniquely account for indirect costs (overhead, accounting, and personnel costs, etc.), in FY 2004, the HSCRC directed hospitals to calculate a specific indirect cost ratio from the hospital's Annual Cost Report data that is used throughout the hospital's CBR inventory worksheet. The model for calculation can be found within the HSCRC's CBR instructions.

While hospitals were directed to use the annual audited cost report data to calculate the ratio, ratios continue to vary widely between hospitals. While the HSCRC permitted indirect costs to be applied to all community benefit categories, for FY 2005 the Commission asked hospitals to pay closer attention to how indirect costs are accounted for, and to consider if direct costs include either a portion or the total of indirect costs for a particular category. Additionally, many hospitals believed that the standard formula that computed indirect costs in the HSCRC reporting spreadsheet did, in fact, overestimate indirect costs for a community benefit reporting category.

An example of the indirect cost ratio issue can be seen when comparing two disparate categories where an identical indirect cost ratio is applied. Using a standardized indirect cost percentage for such items as cash donations, physical and environmental improvements, etc. and medical education, community health services, and charity care, a hospital with a 50% indirect cost ratio that contributes a $100,000 donation to its local United Way organization yields a $50,000 indirect cost value that is applied to the hospital's total CBR activity. As a result, many hospitals suggested that having the option of overriding the standard percentage within a community benefit category may provide a more accurate accounting of community benefits in future reports.

To that end, the HSCRC worked with hospitals to provide hospitals the ability to override the standard indirect cost ratio within the CBR worksheet in FY 2005. In the financial contributions category, for example, 21 Maryland hospitals either reported "$0" when they believed direct costs appropriately captured the total costs of providing the donation or entered a dollar value that differed from the standard percentage calculated by the Community Benefit spreadsheet. The following chart details the changes in Community Benefit Reporting categories from FY 2004 to FY 2005, with a distinction between totals that include and exclude indirect costs.

As described earlier, numerous changes between the FY 2004 and FY 2005 community benefit reporting categories will introduce complications in comparing one year's totals to the next. As such, this chart is meant to be illustrative for the purposes of showing indirect costs and their growth or decline within each community benefit category.

	2005 Net Community Benefit W/Indirect Costs	2004 Net Community Benefit W/Indirect Costs	% Increase from 2004 to 2005 W/Indirect Costs	2005 Net Community Benefit W/O Indirect Costs	2004 Net Community Benefit W/O Indirect Costs	% Increase from 2004 to 2005 W/O Indirect Cost
COMMUNITY HEALTH SERVICES	$45,437,118.30	$ 44,337,326.84	2.48%	$26,355,956.32	$24,655,150.38	6.90%
HEALTH PROFESSIONS EDUCATION	$255,118,493.77	$254,172,270.24	0.37%	$174,572,577.67	$157,787,478.71	10.64%
MISSION DRIVEN HEALTH SERVICES[3]	$120,647,698.17	$105,202,583.45	14.68%	$65,930,115.93	$38,242,676.03	70.99%
RESEARCH	$6,463,049.74	$3,708,261.57	74.29%	$2,046,912.17	$1,412,101.82	44.95%
FINANCIAL CONTRIBUTIONS	$13,112,273.49	$13,185,112.42	-0.55%	$10,850,036.07	$8,188,122.06	32.51%
COMMUNITY BUILDING ACTIVITIES	$11,109,868.13	$9,229,100.09	20.38%	$6,031,135.47	$4,719,448.03	27.79%
CHARITY CARE (report total only)	$194,734,508.78	$150,400,249.96	29.48%	$194,734,508.78	$150,400,249.96	29.48%
FOUNDATION COMMUNITY BENEFIT	$5,678,755.66	$6,308,124.21	-9.98%	$3,625,864.31	$3,668,242.51	-1.16%
TOTALS[4]	$652,301,766.04	$586,543,028.77	11.21%	$484,147,106.73	$389,073,469.50	24.30%
Community Benefit Operations[5]	$3,407,408.66			$2,288,295.83		

In total, community benefit activities overall increased by nearly 3 % (including charity care) without specifically including indirect costs. Including indirect costs, community benefit activities increased by 10.08 % from 2004 to 2005, reflecting the fact that many of Maryland's reporting hospitals adjusted their indirect cost reporting to reflect what they believed to be a more accurate accounting of indirect costs. The HSCRC understands that likely further refinement and understanding of indirect cost reporting must be pursued before its data collection mechanisms and the indirect cost data can be validated.

Community Benefits Evaluation and Community Needs Assessments

During the FY 2004 reporting period, many hospitals had difficulty reporting on community benefit evaluation efforts. Most hospitals have undertaken a community benefits evaluation, but efforts range from patient satisfaction surveys to evaluations of the effectiveness

3 Mission Driven Health Services for FY 2004 includes Grey Areas from the FY 2004 report.
4 Although the FY 2004 report did not contain the Southern Maryland community benefit report, the totals reflected in this chart for FY 2004 do contain Southern Maryland community benefit reporting.
5 Community Benefit Operations was not included in the FY 2004 Report.

of a targeted community benefit initiative. As the community benefit law is broad with regard to evaluation efforts, the Commission asked hospitals to provide information on the steps taken to evaluate the effectiveness of its community benefit initiatives and chose not to prescribe the type of evaluation effort Maryland hospitals should employ. Additionally, the Commission believed it was necessary to focus first year reporting efforts on implementing the new community benefit reporting requirements and achieving as much data consistency between hospitals as possible.

To help hospitals better understand what types of evaluation efforts may have more value, the Commission worked with many interested parties to develop an evaluation framework for hospitals to use in determining appropriate information to submit along with the community benefit data spreadsheet for FY 2005. The evaluation framework contains a list of succinct questions that hospitals can answer (and pose internally) to give the public a better understanding of how a hospital's community benefit are evaluated, if they are incorporated into the facility's overall strategic plan, the sustainability of initiatives, and other related information.

While many hospitals chose to use the new evaluation framework, other hospitals continued to use an existing or hospital specific evaluation description, leading to inconsistency and less comparability in hospital reporting efforts. The Commission, therefore, commits to working with interested parties in further fine-tuning of the evaluation component of the community benefits reporting requirements.

Hospital Rate Support for Community Benefit Programs

In Maryland, the costs of uncompensated care (both charity care and bad debt) and graduate medical education are built into the rates that hospitals are reimbursed by all payers, including Medicare and Medicaid. Additionally, the HSCRC also includes amounts in rates for hospital nurse support programs provided at Maryland hospitals. To avoid accounting confusion between programs that are funded in part or in whole through hospital rate funds (regulated) or programs that are not funded by hospital rate funds (unregulated), the HSCRC asked hospitals not to include revenue provided in rates as offsetting revenue on the CBR worksheet. The following section details the amounts of Nurse Support Program, uncompensated care, and graduate medical education (both direct and indirect), costs that are included in rates for Maryland hospitals in Fiscal Year 2005 funded by all payers.

Nurse Support Program

The Nurse Support Program provides hospitals with grants to increase the recruitment and retention of nurses in Maryland hospitals. In FY 2005, nearly $7.2 million was provided to Maryland hospitals to increase the recruitment and retention of nurses in Maryland hospitals. .

For further information about funding provided to specific hospitals, please see Attachment IV.

Uncompensated Care

The HSCRC includes an amount in hospital rates for uncompensated care; this includes both charity care (eligible for inclusion as a community benefit by Maryland hospitals in their CBRs) and bad debt (not considered a community benefit). In FY 2005, nearly $642million was provided in Maryland hospital rates for the provision of both charity care and hospital bad debt funded by all payers. Hospitals were asked not to include revenue provided through hospital rate

as offsetting revenue on the CBR worksheet.

For further information about funding provided to specific hospitals, please see Attachment IV.

Graduate Medical Education

Another social cost funded in Maryland's rate-setting system is the cost of graduate medical education (GME), generally for interns and residents trained in Maryland hospitals. Graduate medical education costs are divided into direct and indirect medical education components for identification and reimbursement purposes. Direct medical education costs are those directly incurred in the operation of teaching activities and consist of salaries and fringe benefits of residents and interns, faculty supervisory expenses, and allocated overhead. By contrast, indirect medical education expenses are generally described as those additional costs incurred as a result of the teaching program (e.g., increase patient severity associated with teaching programs and inefficiencies, such as extra tests ordered by interns/residents or the extra costs of supervision). The Commission utilizes an annual hospital intern and resident count to assist in quantifying the direct and indirect costs of medical education in physician training programs, and recognizes only the interns and residents included on the survey up the hospital's cap. Any resident and intern costs above the hospital's recognized cap, therefore, would not be funded through hospital rates. For FY 2005, over $394 million was provided to Maryland hospitals to train residents and interns.

For further information about funding provided to specific hospitals, please see Attachment IV.

Conclusion

As stated earlier, the HSCRC views Maryland's Community Benefit Report as an evolving work-in-progress, where the Commission hopes to build upon the successes of the two years' reporting efforts and add to the value of the report in future CBRs. In many instances, individual CBRs represent the first exhaustive inventory of a hospital's community benefits initiatives, one that required hard work and diligence by many Maryland hospital employees. The Commission would like to thank the Maryland Hospital Association, the Institute for Community Health, Local Health Departments, the VHA, the CHA, Maryland hospitals, and many others whose contributions culminated with the production of this report. Finally, we would ask for the continued assistance of these and other groups, as the Commission works to refine and improve the public policy value of Maryland's Community Benefit Report.

Attachment I
Aggregated Hospital CBR Data

Please see Excel Spreadsheet

Attachment II
Individual Hospital Community Benefit Inventory Worksheets
Available at http://www.hscrc.state.md.us September, 2006

Attachment III
Description and Overview of CBR Data Inventory Worksheet

I. Accounting for Community Benefits

In terms of financial accounting practices, the HSCRC directed hospitals to use audited financial statements as the source in calculating costs in care categories.

A. Staff Hours and Number of Encounters

This column includes the number of staff hours associated with and the number of encounters served by the reported community benefit activity[6].

B. Net Community Benefit

The Net Community Benefit column subtracts the sum of the hospital's reported direct and indirect costs from any reported offsetting revenue for each individual community benefit.

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 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 resource and finance departments, insurance, and overhead expenses. Hospitals can currently calculate an indirect cost ratio from their HSCRC Annual Cost Report data or enter a discrete dollar value that may more appropriately capture the value of the indirect costs.

Offsetting revenue includes funds received from external sources (grants, etc.) to provide the individual community benefit reported. Offsetting revenue provided in the form of HSCRC-approved rates to the hospital is not reported in this column.

II. Community Benefit Categories and Reporting Guidelines

As defined under current Maryland law, community benefit means 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.

A. 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 is reported

[6] Note that number of encounters is different than number of people served.

separately as charity care (H Charity Care).

Specific community health services 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

Again, 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."

A1. 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.

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.

Self-help

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

A2. 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. (this is reported in C Mission Driven Health Services).

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.

One-time or occasionally held clinics

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 B1. Medical Education.

Mobile Units

A3. Health Care Support Services

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

A4. Other Areas
Other areas include community benefit initiatives and programs where the recipient is not billed. Please list each program separately and should include only those programs that were not reported elsewhere in a different community benefit reporting category.

B. HEALTH PROFESSIONS EDUCATION
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, offsetting revenue provided in the form of HSCRC-approved rates should not be reported in the "Offsetting Revenue" column.

B1. Physicians/Medical Students
Hospitals report expenses to provide a clinical setting for undergraduate training, internships/clerkships/residencies, residency education, including clinic costs, continuing medical education program, and access and use of medical library by physicians and medical students.

B2. Scholarships/Funding for Professional Education
Hospitals report negative margins for funding, including registrations, fees, travel, and incidental expenses for staff education that is linked to community services and health improvement.

B3. Nurses/nursing students
Hospitals report costs to provide a clinical setting for undergraduate training, training of nurse practitioners in special settings (emergency department, etc.), and access and use of medical library by nurses.

B4. Technicians
Hospitals report costs to provide a clinical setting for undergraduate training for lab and other technicians.

B5. Other Health Professional Education
Hospitals report costs to provide a clinical setting for undergraduate training for dietitians, physical therapists, pharmacists, and other health professionals. Hospitals also report the costs of training of health professionals in special settings (occupational health, outpatient facilities, etc.)

B6. Other
Hospitals count the costs to provide:

- 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

C. 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. Care needs to be taken to ascertain whether the negative contribution is truly a community benefit. The Commission also provides 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." The HSCRC also directs hospitals a checklist of questions developed by VHA and CHA to answer possible questions of whether an activity is appropriately considered a community benefit. Finally, hospitals are asked to include only items that generate a negative margin that have not been otherwise accounted for in a separate Community Benefit reporting section

D. RESEARCH

Research includes clinical and community health research, as well as studies on health care delivery.

D1. Clinical Research

Hospitals include such costs as:

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

D2. Community Health Research

Includes:

- 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

D3. Other

E. FINANCIAL CONTRIBUTIONS

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.

E1. Cash Donations

Hospitals include:

- 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

E2. Grants

Hospitals include the costs of:

- 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

E3. In-Kind Donations

This subcategory includes:

- 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. (health care organization-sponsored community events are reported 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

E4. 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.

F. 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.

F1. Physical Improvements/Housing

Includes:

- 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.

F2. Economic Development
Hospitals include the costs of small business development and participation in economic development council or chamber of commerce in this subcategory.

F3. Support System Enhancements
Typical costs hospitals report in this subcategory include:

- Adopt-a-school efforts
- Child care for community residents with qualified need
- Mentoring programs
- Neighborhood systems or watch groups
- 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

F4. Environmental Improvements
Efforts to reduce environmental hazards in the air, water, and ground, residential improvements (lead, radon programs), and community waste reduction and sharps disposal programs are typically expenses found in this subcategory.

F5. Leadership Development/Training for Community Members
Hospitals include the costs of:

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

F6. Coalition Building
Hospital representation to community coalitions, collaborative partnerships with community groups to improve community health, community coalition meeting costs, visioning sessions, task force meetings, and costs for task force specific projects and initiatives are specific examples of appropriate coalition building costs.

F7. Community Health Improvement Advocacy
Hospitals include the costs of 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, and housing.

F8. Workforce Enhancement
Hospitals include the costs of:
- 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

F9. Other

G. 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.

H. 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.

J. 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.

Attachment IV – Hospital Rate Support for Community Benefit Programs

Nurse Support Program (NSP)

The following chart details awards granted to Maryland hospitals to fund Nursing Support Program to for initiatives to increase the recruitment and retention of nurses in Maryland hospitals in FY 2005:

Hospital	Grant Awarded
Anne Arundel Medical Center	$158,350
Atlantic General Hospital	$35,026
Bon Secours Hospital	$81,428
Calvert Memorial Hospital	$61,409
Carroll County General Hospital	$104,887
Chester River Hospital Center	$39,988
Civista Medical Center	$65,499
Doctors Community Hospital	$117,663
Dorchester General Hospital	$36,401
Franklin Square Hospital	$240,735
Frederick Memorial Hospital	$153,881
Garrett Memorial Hospital	$25,981
Greater Baltimore Medical Center	$265,816
Good Samaritan Hospital	$168,020
Harbor Hospital	$112,668
Harford Memorial Hospital	$52,225
Holy Cross Hospital	$229,248
Howard County General Hospital	$125,884
Johns Hopkins Bayview Medical Center	$305,984
Johns Hopkins	$620,551
Kernan Hospital	$57,685
Laurel Regional Hospital	$76,426
Maryland General Hospital	$133,093
Memorial at Easton	$89,025
Memorial of Cumberland	$81,360
Mercy Medical Center	$206,891
Montgomery General Hospital	$87,224
North Arundel Hospital	$178,017
Northwest Hospital	$133,457
Peninsula Regional Medical Center	$219,723
Prince George's Medical Center	$203,202
Sacred Heart Hospital	$89,272
Saint Agnes Hospital	$228,480
Saint Mary's Hospital	$62,402
Saint Joseph's Hospital	$245,634
Sinai Hospital	$380,307
Southern Maryland Hospital	$149,739
Suburban Hospital	$146,985
University of Maryland Medical Center	$508,386
University of Maryland Cancer Center	$50,509
University of Maryland Shock Trauma	$130,495
Union Memorial Hospital	$245,700
Union Hospital of Cecil	$76,740

Upper Chesapeake Medical Center	$92,077
Washington Adventist Hospital	$205,740
Washington County Hospital	$147,650
Total Grants Awarded	**$7,227,863**

Uncompensated Care

The HSCRC includes amount in hospital rates for uncompensated care; this includes both charity care (eligible for inclusion as a community benefit by Maryland hospitals in their CBRs) and bad debt (not considered a community benefit). This chart, therefore, illustrates the total amount a hospital received for both charity care and bad debt in FY 2005.

Hospital	Uncompensated Care in Rates
Anne Arundel Medical Center	$11,447,886
Atlantic General	$2,781,140
Bon Secours	$9,955,143
Calvert Memorial	$4,526,805
Carroll County General	$6,713,567
Chester River Hospital Center	$4,012,267
Civista Medical Center	$4,887,481
Doctors	$10,572,590
Dorchester General	$3,039,042
Fort Washington Medical Center	$3,343,901
Franklin Square	$22,455,891
Frederick Memorial Hospital	$9,826,463
Garrett County	$1,844,447
Good Samaritan	$16,312,643
Greater Baltimore Medical Center	$8,620,891
Harbor Hospital Center	$13,917,233
Harford Memorial	$5,490,475
Holy Cross	$19,207,689
Howard County	$9,234,801
Kernan	$4,324,896
Johns Hopkins Bayview	$36,819,810
Johns Hopkins	$67,061,461
Laurel Regional	$12,166,147
Maryland General	$13,437,466
McCready	$1,244,800
Memorial at Easton	$8,480,359
Mercy Medical Center	$23,424,381
Montgomery General	$5,724,014
North Arundel	$13,355,457
Northwest	$10,969,694
Peninsula Regional Medical Center	$15,525,873
Prince Georges	$35,271,356
Sacred Heart	$3,819,795
Shady Grove Adventist	$12,130,876
Sinai	$34,423,284
Southern Maryland Hospital	$10,056,323
St. Agnes Hospital	$20,174,529

St. Josephs	$8,922,635
St. Marys	$3,904,293
Suburban	$6,523,007
Memorial of Cumberland	$3,446,573
Union Hospital	$5,426,317
Union Memorial Hospital	$25,291,369
Univ. of Maryland Medical System	$59,978,241
Upper Chesapeake Medical Center	$6,991,028
Washington Adventist	$12,437,052
Washington County Hospital	$12,380,269
TOTAL	**$641,901,660**

Graduate Medical Education

The Commission utilizes an annual hospital intern and resident count to assist in quantifying the direct and indirect costs of medical education in physician training programs, and recognizes only the interns and residents included on the survey up the hospital's cap. Any resident and intern costs above the hospital's recognized cap, therefore, would not be funded through hospital rates. Further, the amounts are differentiated by direct and indirect costs. Direct medical education costs are those directly incurred in the operation of teaching activities and consist of salaries and fringe benefits of residents and interns, faculty supervisory expenses, and allocated overhead. Indirect medical education costs, by contrast, are generally described as those additional costs incurred as a result of the teaching program (e.g., increased patient severity associated with teaching programs and inefficiencies, such as ordering extra tests or the extra costs of supervision).

The following chart illustrates the amount in hospital rates for graduate medical education for FY 2005:

HOSPITAL	IME	DME	TOTAL
Anne Arundel Medical Center	$0	$0	$0
Atlantic General Hospital	$0	$0	$0
Bon Secours Hospital	$0	$0	$0
Calvert Memorial Hospital	$0	$0	$0
Carroll County General Hospital	$0	$0	$0
Chester River Hospital Center	$0	$0	$0
Civista Medical Center	$0	$0	$0
Doctors Community Hospital	$0	$0	$0
Dorchester General Hospital	$0	$0	$0
Fort Washington Medical Center	$0	$0	$0
Franklin Square Hospital Center	$20,278,325	$3,238,137	$23,516,462
Frederick Memorial Hospital	$0	$0	$0
Garrett County Memorial Hospital	$0	$0	$0
GBMC	$13,624,555	$2,076,991	$15,701,546
Good Samaritan Hospital	$7,572,059	$1,701,678	$9,273,737
Harbor Hospital Center	$9,405,394	$1,574,823	$10,980,217
Harford Memorial Hospital	$0	$0	$0
Holy Cross Hospital	$7,802,278	$1,791,759	$9,594,037

Howard County General Hospital	$0	$0	$0
James Lawrence Kernan Hospital	$1,019,317	$349,790	$1,369,107
Johns Hopkins Bayview Medical	$24,342,877	$4,055,852	$28,398,729
Johns Hopkins Hospital	$90,504,552	$18,328,052	$108,832,605
Laurel Regional Hospital	$0	$0	$0
Maryland General Hospital	$7,957,136	$1,938,466	$9,895,601
McCready Memorial Hospital	$0	$0	$0
Memorial Hospital at Easton	$0	$0	$0
Memorial of Cumberland	$0	$0	$0
Mercy Medical Center	$13,320,036	$2,754,585	$16,074,621
Montgomery General Hospital	$0	$0	$0
North Arundel Hospital	$973,200	$139,134	$1,112,334
Northwest Hospital Center	$0	$0	$0
Peninsula Regional Medical Center	$0	$0	$0
Prince Georges Hospital Center	$8,920,244	$2,265,148	$11,185,393
Sacred Heart Hospital	$0	$0	$0
Shady Grove Adventist Hospital	$0	$0	$0
Sinai Hospital	$25,684,857	$4,649,508	$30,334,364
Southern Maryland Hospital Center	$0	$0	$0
St. Agnes Hospital	$16,119,089	$3,516,028	$19,635,117
St. Joseph Medical Center	$0	$0	$0
St. Mary's Hospital	$0	$0	$0
Suburban Hospital	$467,289	$89,383	$556,671
Union Memorial Hospital	$14,379,008	$2,427,965	$16,806,974
Union of Cecil	$0	$0	$0
University of Maryland Hospital	$62,483,172	$18,464,430	$80,947,601
Upper Chesapeake Medical Center	$0	$0	$0
Washington Adventist Hospital	$0	$0	$0
Washington County Hospital	$0	$0	$0
TOTAL	$324,853,388	$69,361,729	$394,215,117

Attachment V - Additional Available Items for Individual Hospitals Not Included in Statewide CBR

(Available in hard copy at HSCRC offices)

- Charity care policies
- Mission statements
- Evaluation descriptions
- Community needs assessments used, if applicable