maryland
health services
cost review commission

# Hospital Community Benefit Reporting Instructions Workgroup

April 17, 2024

# Agenda

- Introductions
- Background
- Workgroup Charge and Timeline
- Discussion: Indirect Cost Ratios
- Next Meeting: May 1

# Introductions

# Hospital Community Benefit (HCB) Background

# Overview of Maryland HCB Reporting Requirements

- MD law defines HCB as a planned, organized, and measured activity that is intended to meet identified community health needs within a service area.
- Examples include:
  - Community health services
  - Health professional education
  - Research
  - Financial contributions
  - Community-building activities
  - Community benefit operations
  - Charity care
  - Mission-driven health services

# Recent Legislation in Maryland

- HB1169/SB0774 of the 2020 Legislative Session updated §19-303 of the Health General Article.
- CB reporting requirement updates:
  - Updated the definition of CB
  - More closely tied initiatives back to the community health needs assessment (CHNA)
  - Required listing of tax exemptions the hospital claimed during the preceding year

# Previous Working Groups

- To implement the new requirements in the 2020 legislation, HSCRC convened the Consumer Standing Advisory Community and a Technical Subgroup in the summer and fall of 2020.
- Submitted a legislative report with recommendations in December 2020.
- All changes were required from FY 2022 forward.

# Key Changes for FY 2022 Reporting

- Provided a list of itemized HCB expenditures that address CHNA priority areas.
- Collected data on physician subsidies in line-item detail.
- These new data were presented to the Commission in the fall of 2023.

# FY 2022 HCB Financial Report Highlights

- 51 hospitals submitted.
- $2.06 billion in gross community benefit expenditures, compared to $1.95 billion in FY 2021.
  - Represents 10.6% of statewide hospital operating expenses compared to 10.7% in FY 2021.
  - Among individual hospitals, this percentage ranges from 3.2% to 25.5%.
- After accounting for rate support, net community benefit expenses totaled $1.21 billion, compared with $1.20 billion in FY 2021.
  - Represents 6.2% of statewide hospital operating expenses, compared to 6.6% in FY 2021.
  - Among individual hospitals, this percentage ranges from 2.0% to 24.7%.

# FY 2022 HCB Expenditures by Category

| Community Benefit Category | Gross Community Benefit Expense | % Gross Total CB Expenditures | Net Community Benefit Expense Less Hospital-reported Rate Support | % Net Total CB Expenditures w/o Rate Support |
|---|---|---|---|---|
| Unreimbursed Medicaid Cost | $55,621,777 | 2.69% | $55,621,777 | 4.58% |
| Community Health Services | $156,476,493 | 7.58% | $129,452,584 | 10.66% |
| Health Professions Education | $661,694,610 | 32.05% | $214,685,520 | 17.67% |
| Mission Driven Health Services | $724,532,073 | 35.09% | $724,532,073 | 59.64% |
| Research | $12,155,232 | 0.59% | $12,155,232 | 1.00% |
| Financial Contributions | $20,867,653 | 1.01% | $20,867,653 | 1.72% |
| Community Building | $30,678,428 | 1.49% | $30,678,428 | 2.53% |
| Community Benefit Operations | $14,062,045 | 0.68% | $14,062,045 | 1.16% |
| Foundation | $1,839,390 | 0.09% | $1,839,390 | 0.15% |
| Charity Care | $386,716,607 | 18.73% | $10,985,064 | 0.90% |
| **Total** | **$2,064,644,308** | **100%** | **$1,214,879,766** | **100%** |

# Workgroup Charge and Timeline

# Workgroup Ground Rules

- Be brief.
- Share the floor: raise your hand and the facilitator will call on participants.
- No interruptions (except for the time-keeper).
- Stay on topic.
- Questions are welcome.

# Workgroup Charge

- After reviewing the results of the FY 2022 reports, Commissioners charged staff with convening this short-term technical Workgroup to review reporting instructions in 2 areas:
  - Indirect Cost Ratios – Noting wide variation across hospitals, the Workgroup will review the methodology for calculating indirect costs and will advise staff about possible changes to this methodology, including whether thresholds are appropriate (**Today's Topic).**
  - CHNA-Aligned Spending – Noting wide variation across hospitals, the Workgroup will review the criteria hospitals are using to determine whether expenditures are CHNA-related. The Workgroup will advise staff about whether reporting instructions should provide additional guidance.
- This Workgroup is limited to these two topics.

# Guiding Principles

- Community benefit reporting should capture community benefit efforts and spending as accurately and comprehensively as possible.
- To the extent feasible, community benefit reporting will be based on best practices.
- Community benefit data collected will allow for meaningful comparison between hospitals.
- To the extent feasible, the Workgroup's decisions will be data-driven and based on objective criteria.
- Community benefit reporting will comply with state statutory requirements.

# Timeline

| Activity | Timeline |
|---|---|
| Finalize Workgroup Charge | March |
| Schedule Workgroup Meetings | March |
| Recruit Workgroup Members | March |
| Brief Commissioners | March 13 |
| Meeting 1 | April 17, 2:30-4:30 |
| Meeting 2 | May 1, 10:00-12:00 |
| Meeting 3 | May 15, 1:00-3:00 |
| Final Workgroup Comments on Reporting Instruction Edits | May 31 |
| Release Final FY 2024 Reporting Instructions | July 1 |

# Discussion: Indirect Costs

# Indirect Costs: Current Definition and Instructions

- Definitions: Costs not attributed to products and/or services that are included in the calculation of costs for community benefit, including but not limited to, salaries for human resources and finance departments, insurance, and overhead expenses.
- Instructions: Refer to HSCRC's Annual Cost Report Schedule M:
  - 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).
  - Determine Direct Expenses: Add the total of columns #2 (Direct Expenses), #6 (Physician Support Expenses), and #7 (Resident Intern Expenses).
  - 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.

# Indirect Costs: Current Instructions continued

- Hospitals can 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.
- Indirect costs generally may not be reported for categories (E) Cash and In-Kind Contributions and (H) Charity Care.
- 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 (CHA) recommends a 10-15 percent indirect cost rate for community-based programs.

# Indirect Costs: Current Instructions continued

- For research activities, the hospital should apply any federally-approved rates from the National Institute of Health as applicable.
- 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.

# Indirect Costs in FY 2022 HCB Report

| Hospital Name | Indirect Cost Ratio | | Hospital Name | Indirect Cost Ratio | | Hospital Name | Indirect Cost Ratio | |
|---|---|---|---|---|---|---|---|---|
| | Hospital-Based | Community-Based | | Hospital-Based | Community-Based | | Hospital-Based | Community-Based |
| UM Shore Dorchester | 163.2% | 9.0% | UM BWMC | 82.0% | 13.3% | UM Rehab & Ortho | 66.9% | |
| UM Shore Chester | 137.5% | 15.4% | MedStar Harbor | 80.9% | | UPMC Western Maryland | 65.5% | 54.9% |
| UM Shore Easton | 103.9% | 10.7% | UM Capital Region | 80.3% | 13.7% | Johns Hopkins Bayview | 64.6% | 17.1% |
| Adventist Rehab | 103.8% | 15.0% | Adventist Shady Grove | 79.9% | | Adventist White Oak | 60.7% | |
| Sheppard Pratt | 97.1% | | Mercy Medical Center | 78.4% | 10.0% | Adventist Fort Washington | 59.9% | |
| UM Charles Regional | 95.0% | 17.8% | LifeBridge Sinai | 78.3% | 12.0% | Garrett Regional Medical Center | 59.5% | |
| LifeBridge Northwest | 91.4% | 12.0% | LifeBridge Grace | 78.0% | 12.0% | University of Maryland Medical Center | 59.2% | 9.8% |
| LifeBridge Levindale | 90.0% | | MedStar Good Samaritan | 77.4% | | TidalHealth Peninsula Regional | 57.0% | |
| MedStar Southern Maryland | 89.7% | | Suburban Hospital | 75.8% | 28.1% | MedStar Franklin Square | 56.5% | |
| UMMC Midtown | 88.4% | 14.7% | UM Harford Memorial | 74.4% | 11.0% | UM Upper Chesapeake | 53.0% | 8.0% |
| GBMC | 87.5% | | CalvertHealth Medical Center | 74.4% | 33.0% | Carroll Hospital Center | 50.0% | 12.0% |
| Doctors Community Medical Center | 86.8% | | Mt. Washington Pediatric | 73.0% | 11.4% | Johns Hopkins Hospital | 46.9% | 15.4% |
| McNew Family Health Center | 86.2% | | MedStar St. Mary's | 72.3% | | MedStar Union Memorial | 46.5% | |
| Frederick Health Hospital | 85.8% | 85.8% | TidalHealth McCready Pavilion | 72.1% | | Atlantic General Hospital | 35.3% | |
| Howard County General Hospital | 85.7% | 19.5% | Anne Arundel Medical Center | 71.2% | | Holy Cross Germantown | 31.1% | |
| Saint Agnes | 85.3% | 10.0% | Meritus Medical Center | 70.0% | 13.1% | Holy Cross Hospital | 28.8% | |
| UM St. Joseph | 82.7% | 15.4% | MedStar Montgomery | 68.7% | 0.0% | ChristianaCare, Union | 0.4% | |

# Indirect Cost Ratios Reported on Schedule M

| Hospital | FY 22 Indirect Cost Ratio | FY 23 Indirect Cost Ratio | Hospital | FY 22 Indirect Cost Ratio | FY 23 Indirect Cost Ratio | Hospital | FY 22 Indirect Cost Ratio | FY 23 Indirect Cost Ratio |
|---|---|---|---|---|---|---|---|---|
| UM Shore Chester | 137.5% | 144.8% | GBMC | 87.5% | 80.6% | Mt Washington Pediatric | 72.9% | 64.2% |
| UM Shore Cambridge | 163.2% | 144.8% | MedStar Montgomery | 69.9% | 78.6% | Suburban Hospital | 75.8% | 64.2% |
| UM Bowie ED | 97.7% | 109.8% | MedStar St Mary's | 74.7% | 78.3% | MedStar Union Memorial | 46.9% | 63.7% |
| LifeBridge Levindale | 102.6% | 108.0% | Atlantic General | 76.4% | 78.2% | Adventist White Oak | 60.4% | 63.7% |
| UM Shore Easton | 103.9% | 105.8% | UM BWMC | 81.9% | 76.5% | Holy Cross Germantown ED | 57.7% | 63.4% |
| UM Laurel | 87.6% | 103.6% | CalvertHealth Medical Center | 74.4% | 76.5% | TidalHealth McCready Pavilion | 72.1% | 63.3% |
| Brook Lane Health Services | 107.0% | 97.5% | UM St. Joseph | 82.7% | 72.8% | UPMC Western MD | 65.5% | 63.1% |
| LifeBridge Northwest | 95.6% | 94.7% | MedStar Good Samaritan | 78.7% | 71.6% | ChristianaCare, Union | 66.3% | 60.9% |
| UM Charles Regional | 95.0% | 93.2% | Adventist Fort Washington | 59.8% | 71.5% | Holy Cross Germantown | 74.1% | 60.9% |
| UM Capital Region | 94.3% | 90.7% | UM Rehab & Ortho | 66.9% | 71.1% | Garrett Regional Medical Center | 64.3% | 59.5% |
| Saint Agnes | 88.3% | 89.5% | LifeBridge Sinai | 78.3% | 70.2% | University of Maryland Medical Center | 58.9% | 56.7% |
| Carroll Hospital Center | 83.4% | 88.3% | UM Harford Memorial | 74.4% | 69.9% | UM Upper Chesapeake | 52.9% | 54.9% |
| MedStar Harbor | 84.4% | 87.8% | Howard County General | 85.7% | 69.8% | Anne Arundel Medical Center | 71.2% | 53.0% |
| LifeBridge Grace | 119.8% | 85.3% | UM Shock Trauma | 62.3% | 68.4% | TidalHealth Peninsula Regional | 57.0% | 52.7% |
| Mercy Medical Center | 78.4% | 84.4% | Doctors Community Medical Center | 86.8% | 68.3% | Johns Hopkins Bayview | 64.6% | 51.6% |
| McNew Family Health Center | 86.2% | 83.3% | MedStar Franklin Square | 57.0% | 67.0% | Johns Hopkins Hospital | 46.9% | 45.1% |
| MedStar Southern Maryland | 90.4% | 83.3% | Holy Cross Hospital | 65.9% | 66.5% | UM Queen Anne's ED | 70.1% | 43.4% |
| UMMC Midtown | 88.4% | 82.7% | Meritus Medical Center | 70.0% | 66.2% | Sheppard Pratt | 39.0% | 29.4% |
| Frederick Health Hospital | 85.8% | 81.1% | Adventist Shady Grove | 79.7% | 64.9% | **Statewide Total** | **67.83%** | **64.63%** |
| | | | | | | **FY 23 Estimate Excluding 1/3 Non-Relevant Indirects** | | **43.30%** |

# Indirect Cost Ratios Reported on Schedule M

- Staff identified errors in column references to Schedule M in HCB instructions.
- Some hospitals' indirect costs do not align between HCB report and schedule M.
- Some categories of indirect costs in Schedule M may not be applicable to HCB, such as:
  - Nursing administration, medical records, laundry and linen, dietary, central services and supplies, pharmacy, and patient accounting.
  - If we exclude these categories, statewide indirect costs reported on Schedule M decrease from 63.6% to 43.3%.

# IRS 990 Schedule H Instructions

- Defines indirect costs as those that “are shared by multiple activities or programs, such as facilities and administrative costs related to the organization's infrastructure (space, utilities, custodial services, security, information systems, administration, materials management, and others).”
- Under the “research” HCB category, directs hospitals to follow their NIH guidelines.
- Otherwise silent on further guidance on indirect costs.

# Catholic Health Association (CHA) Recommended Practices

- Recommends that hospitals use their cost accounting systems to assign indirect costs.
- Recommends that hospitals use at least 3 indirect rates:
  - Highest rate applied to programs that are based in the hospital, receive support services, and take up space, e.g., 35-45%.
  - Lower for community-based programs outside of the hospital walls, e.g., 10-15%.
  - Use federally-approved NIH rate for HCB classified as research.

# Modeling of Indirect Costs at 25% as an Example

- 25% is the indirect rate developed for HSCRC's population health reports and is within the ranges recommended by CHA.
- Modeled applying 25% to all categories except:
  - Research – left as is at federally-approved rates.
  - Medicaid Deficit Assessment, Charity Care, & Cash/In-Kind – left at 0% per current instructions.
  - Physician Subsidy Sub-Category of Mission-Driven Services – modeled at 0% indirect.
- Overall change is a decrease in statewide expenditures of 10.6%, but variation across hospitals

# Results by Hospital with 25% Modeling

| Hospital | % Difference in Total Net CB | Hospital | % Difference in Total Net CB | Hospital | % Difference in Total Net CB |
|---|---|---|---|---|---|
| Adventist White Oak | 106.3% | MedStar Montgomery | -1.6% | Howard County General | -9.9% |
| ChristianaCare, Union | 36.9% | Frederick Health Hospital | -2.4% | Johns Hopkins Hospital | -10.1% |
| Adventist Rehab | 24.8% | UM Upper Chesapeake | -2.9% | Holy Cross Germantown | -11.7% |
| LifeBridge Grace | 16.5% | UM Charles Regional | -3.0% | UM Shore Easton | -12.5% |
| Garrett Regional Medical Center | 12.4% | TidalHealth Peninsula Regional | -3.9% | UMMC Midtown | -12.7% |
| Fort Washington | 8.1% | LifeBridge Levindale | -4.3% | Johns Hopkins Bayview | -14.2% |
| Doctors Medical Center | 2.3% | MedStar Harbor | -4.7% | TidalHealth McCready Pavilion | -16.3% |
| Atlantic General | 2.3% | UM Shore Dorchester | -5.0% | University of Maryland Medical Center | -21.3% |
| GBMC | 2.3% | UM BWMC | -6.3% | Mt Washington Pediatric | -22.1% |
| UM Capital Region | 1.8% | UM Harford Memorial | -6.6% | CalvertHealth | -23.5% |
| McNew Family Health Center | 1.5% | MedStar Union Memorial | -6.6% | Mercy Medical Center | -24.5% |
| MedStar Southern Maryland | 0.5% | MedStar Franklin Square | -6.7% | Lifebridge Sinai | -26.4% |
| Meritus Medical Center | 0.5% | Anne Arundel Medical Center | -6.9% | UM Rehab & Ortho Institute | -28.6% |
| Saint Agnes | 0.3% | UM Shore Chester | -7.0% | LifeBridge Northwest | -29.6% |
| Shady Grove | -0.3% | Holy Cross Hospital Center | -7.6% | Sheppard Pratt | -37.7% |
| Carroll Hospital Center | -0.6% | MedStar Good Samaritan | -7.7% | UM St Joseph | -38.1% |
| MedStar St Mary's | -1.5% | Suburban Hospital | -9.3% | UPMC Western MD | -47.3% |
| | | | | **Statewide Total** | **-10.6%** |

# Discussion of Options/Potential Changes

- Option 1: Clarify current instructions for deriving indirect costs from Schedule M to remove categories that are inappropriate for HCB, such as:
  - Nursing administration, medical records, laundry and linen, dietary, central services and supplies, pharmacy, and patient accounting
- Option 2: Move to a set indirect cost threshold not to exceed a specified amount, such as 25%, with exceptions for:
  - Research to remain at federally-approved rate.
  - Medicaid deficit assessment, charity care, and cash/in-kind to remain at 0%.

# Discussion of Options/Potential Changes

- Option 3: Combination of the above:
  - Hospitals submit their individual reports based on Schedule M, as updated to remove inappropriate costs.
  - For the statewide summary report, HSCRC replaces hospital-reported rates with the set threshold.
- Consideration for all options: Apply no indirect costs for physician subsidies.

# Next Meeting: May 1, 10-12
# Discussion Topic: CHNA-Aligned Spending