



SUSTAINABILITY ACCOUNTING STANDARD | HEALTH CARE SECTOR

HEALTH CARE DELIVERY

Sustainability Accounting Standard

Sustainable Industry Classification System™ (SICS™)# HC0301

Prepared by the
Sustainability Accounting Standards Board®

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HEALTH CARE DELIVERY

Sustainability Accounting Standard

About SASB

The Sustainability Accounting Standards Board (SASB) provides sustainability accounting standards for use by publicly-listed corporations in the U.S. in disclosing material sustainability issues for the benefit of investors and the public. SASB standards are designed for disclosure in mandatory filings to the Securities and Exchange Commission (SEC), such as the Form 10-K and 20-F. SASB is an independent 501(c)3 non-profit organization and is accredited to set standards by the American National Standards Institute (ANSI).

SASB is developing standards for more than 80 industries in 10 sectors. SASB's standards-setting process includes evidence-based analysis with in-depth industry research and engagement with a broad range of stakeholders. The end result of this process is the creation of a complete, industry-specific accounting standard which accurately reflects the material issues for each industry.

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INTRODUCTION

Purpose and Structure

This document contains the SASB Sustainability Accounting Standards (SASB Standards) for Health Care Delivery.

SASB Standards are comprised of **(1) disclosure guidance and (2) accounting standards on sustainability topics** for use by U.S. and foreign public companies in their annual filings (Form 10-K or 20-F) with the U.S. Securities and Exchange Commission (SEC). To the extent relevant, SASB Standards may also be applicable to other periodic mandatory filings with the SEC, such as the Form 10-Q, Form S-1, and Form 8-K.

SASB's **disclosure guidance** identifies sustainability topics at an industry level and—depending on the specific operating context of a company—may be material to a company within that industry. Each company is ultimately responsible for determining which information is material, and which such company is therefore required to include in its Form 10-K or 20-F and other periodic SEC filings.

SASB's **accounting standards** provide companies with standardized accounting metrics to account for performance on industry-level sustainability topics. When making disclosure on sustainability topics, companies adopting SASB's accounting standards will help to ensure that disclosure is standardized and therefore useful, relevant, comparable and auditable.

Guidance for Disclosure of Material Sustainability Topics in SEC filings

1. Industry-Level Material Sustainability Topics

For the Health Care Delivery Industry, SASB has identified the following material sustainability topics:

- **Quality of Care and Patient Satisfaction**
- **Access for Low Income Patients**
- **Employee Recruitment, Development, and Retention**
- **Pricing and Billing Transparency**
- **Energy and Waste Efficiency**
- **Climate Change Impacts on Human Health and Infrastructure**
- **Fraud and Unnecessary Procedures**
- **Patient Privacy and Electronic Health Records**

NOTE: A description of each topic is provided alongside standard accounting metrics in the rest of this document.

2. Company-Level Determination and Disclosure of Material Sustainability Topics

Sustainability disclosures are governed by the same laws and regulations that govern disclosures by securities issuers generally. According to the U.S. Supreme Court, a fact is material if, in the event such fact is omitted from a particular disclosure, there is “a substantial likelihood that the disclosure of the omitted fact would have been viewed by the reasonable investor as having significantly altered the ‘total mix’ of the information made available”.¹

SASB has attempted to identify those sustainability topics (above) that it believes may be material for all companies within the Health Care Delivery Industry. SASB recognizes, however, that each company is ultimately responsible for determining what is material to it.

Regulation S-K, which sets forth certain disclosure requirements associated with Form 10-K and other SEC filings, requires companies, among other things, to describe in the Management’s Discussion and Analysis of Financial Condition and Results of Operations (MD&A) section of Form 10-K “any known trends or uncertainties that have had or that the registrant reasonably expects will have a material favorable or unfavorable impact on net sales or revenues or income from continuing operations. If the registrant knows of events that will cause a material change in the relationship between costs and revenues (such as known future increases in costs of labor or materials or price increases or inventory adjustments), the change in the relationship shall be disclosed.”²

Furthermore, Instructions to Item 303 state that the MD&A “shall focus specifically on material events and uncertainties known to management that would cause reported financial information not to be necessarily indicative of future operating results or of future financial condition.”

In determining whether a trend or uncertainty should be disclosed, the SEC has stated that management should use a two-part assessment based on probability and magnitude:

- First, a company is not required to make disclosure about a known trend or uncertainty if its management determines that such trend or uncertainty is not reasonably likely to occur.
- If a company’s management cannot make a reasonable determination of the likelihood of an event or uncertainty, then disclosure is required unless management determines that a material effect on the registrant’s financial condition or results of operation is not reasonably likely to occur.

3. Sustainability Accounting Standard Disclosures in Form 10-K

a. Management’s Discussion and Analysis

Companies should consider making disclosure on sustainability topics as a complete set in the MD&A, in a subsection titled **“Sustainability Accounting Standards Disclosures.”**³

b. Other Relevant Sections of Form 10-K

¹ TSC Industries v. Northway, Inc., 426 U.S. 438 (1976).

² 17 C.F.R. 229.303(Item 3030)(a)(3)(ii).

³ SEC [Release Nos. 33-8056; 34-45321; FR-61] [Commission Statement about Management’s Discussion and Analysis of Financial Condition and Results of Operations](#): “We also want to remind registrants that disclosure must be both useful and understandable. That is, management should provide the most relevant information and provide it using language and formats that investors can be expected to understand. Registrants should be aware also that investors will often find information relating to a particular matter more meaningful if it is disclosed in a single location, rather than presented in a fragmented manner throughout the filing.”

In addition to the MD&A section, companies should consider disclosing sustainability information in other sections of Form 10-K, as relevant, including:

- **Description of business**—Item 101 of Regulation S-K requires a company to provide a description of its business and its subsidiaries. Specifically Item 101(c)(1)(xii) expressly requires disclosure regarding certain costs of complying with environmental laws:

Appropriate disclosure also shall be made as to the material effects that compliance with Federal, State and local provisions which have been enacted or adopted regulating the discharge of materials into the environment, or otherwise relating to the protection of the environment, may have upon the capital expenditures, earnings and competitive position of the registrant and its subsidiaries.

- **Legal proceedings**—Item 103 of Regulation S-K requires companies to describe briefly any material pending or contemplated legal proceedings. Instructions to Item 103 provide specific disclosure requirements for administrative or judicial proceedings arising from laws and regulations targeting discharge of materials into the environment or primarily for the purpose of protecting the environment.
- **Risk factors**—Item 503(c) of Regulation S-K requires filing companies to provide a discussion of the most significant factors that make an investment in the registrant speculative or risky, clearly stating the risk and specifying how a particular risk affects the particular filing company.
- **Rule 12b-20**—Securities Act Rule 408 and Exchange Act Rule 12b-20 require a registrant to disclose, in addition to the information expressly required by law or regulation, “such further material information, if any, as may be necessary to make the required statements, in light of the circumstances under which they are made, not misleading.”

More detailed guidance on disclosure of material sustainability topics can be found in the **SASB Conceptual Framework**, available for download via <http://www.sasb.org/approach/conceptual-framework/>

Guidance on Accounting of Material Sustainability Topics

For material sustainability topics in the Health Care Delivery Industry, SASB identified the accounting metrics below in **Table 1. Material Sustainability Topics & Accounting Metrics**.

SASB recommends that each company consider using these sustainability accounting metrics when disclosing their performance with respect to each of the sustainability topics it has identified as material.

As appropriate—and consistent with Rule 12b-20⁴—for each sustainability topic, companies should consider including a narrative description of any material factors necessary to ensure completeness, accuracy and comparability of the data reported. Where not addressed by the specific accounting metrics, but relevant, the registrant should discuss the following related to the topic:

⁴ SEC Rule 12b-20: “In addition to the information expressly required to be included in a statement or report, there shall be added such further material information, if any, as may be necessary to make the required statements, in the light of the circumstances under which they are made not misleading.”

- the registrant's **strategic approach** to managing performance on material sustainability issues;
- the registrant's **competitive positioning**;
- the **degree of control** the registrant has;
- any **measures the registrant has undertaken** or **plans to undertake** to improve performance; and
- data for registrant's **last three completed fiscal years** (when available).

SASB recommends that registrants use SASB Standards specific to their primary industry as identified in the [Sustainability Industry Classification System \(SICS™\)](#). If a registrant generates significant revenue from multiple industries, SASB recommends that it consider the materiality of the sustainability issues that SASB has identified for those industries and disclose the associated SASB accounting metrics.

Users of the SASB Standards

The SASB Standards are intended for companies that engage in public offerings of securities registered under the Securities Act of 1933 (the Securities Act) and those that issue securities registered under the Securities Exchange Act of 1934 (the Exchange Act)⁵, for use in SEC filings, including, without limitation, annual reports on Form 10-K (Form 20-F for foreign issuers), quarterly reports on Form 10-Q, current reports on Form 8-K, and registration statements on Forms S-1 and S-3. Nevertheless, disclosure with respect to the SASB Standards is not required or endorsed by the SEC or other entities governing financial reporting, such as FASB, GASB, or IASB.

Scope of Disclosure

Unless otherwise specified, SASB recommends:

- That a registrant disclose on sustainability issues and metrics for itself and for entities in which the registrant has a controlling interest and therefore are consolidated for financial reporting purposes (controlling interest is generally defined as ownership of 50% or more of voting shares);⁶
- That for consolidated entities, disclosures be made, and accounting metrics calculated, for the whole entity, regardless of the size of the minority interest; and
- That information from unconsolidated entities not be included in the computation of SASB accounting metrics. A registrant should disclose, however, information about unconsolidated entities to the extent that such registrant considers the information necessary for investors to understand its performance with respect to sustainability issues (typically this disclosure would be limited to risks and opportunities associated with these entities).

⁵ Registration under the Securities Exchange Act of 1934 is required (1) for securities to be listed on a national securities exchange such as the New York Stock Exchange, the NYSE Amex and the NASDAQ Stock Market or (2) if (A) the securities are equity securities and are held by more than 2,000 persons (or 500 persons who are not accredited investors) and (B) the company has more than \$10 million in assets.

⁶ See US GAAP consolidation rules (Section 810).

Reporting Format

Normalization

SASB recognizes that normalizing accounting metrics is important for the analysis of SASB disclosures.

SASB recommends that a registrant disclose any basic operational data that may assist in the accurate evaluation and comparability of disclosure, to the extent that they are not already disclosed in the Form 10-K (e.g., revenue, EBITDA, etc.).

Such data may include high-level operating data such as total number of employees, quantity of products produced or services provided, number of facilities, or number of customers. It may also include industry-specific data such as plant capacity utilization (e.g., for specialty chemical companies), number of transactions (e.g., for internet media and services companies), hospital bed days (e.g., for health care delivery companies), or proven and probable reserves (e.g., for oil and gas exploration and production companies).

Any operational data provided should:

- Convey contextual information that would not otherwise be apparent from SASB accounting metric
- Be deemed generally useful for users of SASB accounting metrics (e.g., investors) in performing their own calculations and creating their own ratios.

Units of Measure

Unless specified, disclosures should be reported in International System of Units (SI units).

Uncertainty

SASB recognizes that there may be inherent uncertainty when disclosing certain sustainability data and information. This may be related to variables like the imperfectness of third-party reporting systems or the unpredictable nature of climate events. Where uncertainty around a particular disclosure exists, SASB recommends that the registrant should consider discussing its nature and likelihood.

Estimates

SASB recognizes that scientifically-based estimates, such as the reliance on certain conversion factors or the exclusion of *de minimis* values, may be necessary for certain quantitative disclosures. Where appropriate, SASB does not discourage the use of such estimates. When using an estimate for a particular disclosure, SASB expects that the registrant discuss its nature and substantiate its basis.

Timing

Unless otherwise specified, disclosure shall be for the registrant's fiscal year.

Limitations

There is no guarantee that SASB Standards to address all sustainability impacts or opportunities associated with a sector, industry, or company and, therefore, a company must determine for itself the topics—sustainability-related or otherwise—that warrant discussion in a registrant’s SEC filings.

Disclosure under SASB Standards is voluntary. It is not intended to replace any legal or regulatory requirements that may be applicable to user operations. Where such laws or regulations address legal or regulatory topics, disclosure under SASB Standards is not meant to supersede those requirements. Disclosure according to SASB Standards shall not be construed as demonstration of compliance with any law, regulation, or other requirement.

SASB Standards are intended to be aligned with the principles of materiality enforced by the SEC. However, SASB is not affiliated with or endorsed by the SEC or other entities governing financial reporting, such as FASB, GASB, or IASB.

Forward Looking Statements

Disclosures on sustainability topics can involve discussion of future trends and uncertainties related to the registrant’s operations and financial condition, including those influenced by external variables (e.g., environmental, social, regulatory and political). Companies making such disclosures should familiarize themselves with the safe harbor provisions of Section 27A of the Securities Act and Section 21E of the Exchange Act, which preclude civil liability for material misstatements or omissions in such statements if the registrant takes certain steps, including, among other things, identifying the disclosure as forward looking and accompanying such disclosure with “meaningful cautionary statements identifying important factors that could cause actual results to differ materially from those in the forward-looking statements.”

Assurance

In reporting on SASB Standards, it is expected that registrants report with the same level of rigor, accuracy, and responsibility as all other information contained in their SEC filings.

SASB recommends registrants use a higher level of assurance (attestation), such as an Examination Engagement to AT Section 701.

The following sections contain the technical protocols associated with each accounting metric such as guidance on definitions, scope, accounting guidance, compilation, and presentation.

The term “shall” is used throughout this Standard to indicate those elements that reflect SASB’s mandatory disclosure requirements. The terms “should” and “may” are used to indicate guidance, which, although not mandatory, provides a recommended means of disclosure.

Table 1. Material Sustainability Topics & Accounting Metrics

TOPIC	CODE	ACCOUNTING METRIC
Quality of Care and Patient Satisfaction	HC0301-01	Hospital Values Based Purchasing Total Performance score, broken down by Clinical Process Domain score, Outcome Domain score, and Patient Experience Domain score.
	HC0301-02	Number of Serious Reportable Events (SREs) as defined by the National Quality Forum.
	HC0301-03	Health care-acquired infections, as defined by the CDC's National Healthcare Safety Network, for: (1) Central Line-associated Bloodstream Infections (CLABSIs); (2) Surgical Site Infections (SSIs); (3) Catheter-associated Urinary Tract Infections (CAUTIs).
	HC0301-04	Excess readmission ratio for pneumonia, acute myocardial infarction, and heart failure, as defined by the Centers for Medicare & Medicaid Services (CMS). Readmissions Payment Adjustment Amount as part of the Hospital Readmissions Reduction Program.
Access for Low-Income Patients	HC0301-05	Description of strategy to manage the mix of patient insurance status (i.e., private insurance, government insurance, and uninsured), including a description of alternative pricing mechanisms or programs for the uninsured.
	HC0301-06	Amount of Medicare Disproportionate Share Hospital (DSH) adjustment payments received.
Employee Recruitment, Development, and Retention	HC0301-07	Employee turnover by voluntary and involuntary for: (1) physicians, (2) non-physician health care practitioners, and (3) all others.
	HC0301-08	Description of talent recruitment and retention efforts for health care practitioners, such as mentorship programs, flexible scheduling, and leadership development initiatives. Where applicable, participation or utilization rates for each type of effort.
Pricing and Billing Transparency	HC0301-09	Description of policies or initiatives to ensure that patients are adequately informed about price before undergoing a procedure.
	HC0301-10	Description of how pricing information for services (including inpatient and outpatient) is made publicly available, including the number of the registrant's 25 most common services for which pricing information is publicly available, and the percentage of total services performed (by volume) that these represent.
Energy and Waste Efficiency	HC0301-11	Total annual energy consumed (gigajoules) and percentage renewable (e.g., wind, biomass, solar).
	HC0301-12	Total weight of regulated medical waste generation (as defined by the Medical Waste Tracking Act of 1988) and total weight by disposition (e.g., on-site incineration, landfill, treatment/storage/disposal facility, etc.).
	HC0301-13	Total weight of pharmaceutical waste generation and total weight by disposition (e.g., on-site incineration, landfill, Treatment/Storage/Disposal Facility, etc.). Break down by: (1) hazardous waste and (2) non-hazardous (solid) waste.
Climate Change Impacts on Human Health and Infrastructure	HC0301-14	Description of the strategy to address the effects of climate change on business operations, physical infrastructure, and facility design. Discussion of specific risks (such as physical risks) presented by changes in the frequency and intensity of extreme weather events and changes to the morbidity and mortality of illnesses and diseases.

Table 1. Material Sustainability Topics & Accounting Metrics (cont.)

TOPIC	CODE	ACCOUNTING METRIC
Fraud and Unnecessary Procedures	HC0301-15	Description of legal and regulatory fines and settlements associated with Medicare and Medicaid Fraud under the False Claims Act. Dollar amount of fines and settlements and a description of corrective actions implemented in response to events.
Patient Privacy and Electronic Health Records	HC0301-16	Percentage of patient records that are electronic medical records (EMR) or electronic health records (EHR) meeting the Centers for Medicare and Medicaid Services (CMS) "meaningful use" requirements.
	HC0301-17	Description of legal and regulatory fines and settlements associated with Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules violations or The Health Information Technology for Economic and Clinical Health (HITECH) Act violations. Dollar amount of fines and settlements and a description of corrective actions implemented in response to events.

Quality of Care and Patient Satisfaction

Description

The ability to deliver quality care and ensure patient satisfaction is an essential value driver for health care delivery companies. The link between performance in this area and shareholder value has been strengthened by the Patient Protection and Affordable Care Act (PPACA). Included in the Act's provisions is the establishment of the Hospital Value-Based Purchasing Program, which provides incentive payments, based on performance on a series of health care quality measures. Further, hospitals will be subject to reductions in inpatient payments for excessive readmissions and hospital-acquired conditions.

Accounting Metrics

HC0301-01. Hospital Values Based Purchasing Total Performance score, broken down by Clinical Process Domain score, Outcome Domain score, and Patient Experience Domain score.

- .01 The registrant shall disclose the mean Hospital Values Based Purchasing (HVBP) scores for all hospitals it operates, where hospitals are defined as in Section 1886(d)(1)(B) of the Social Security Act. Disclosure shall consist of the mean Total Performance score, mean Clinical Process Domain score, mean Outcome Domain score, and mean Patient Experience Domain score for all hospitals it operates.
- .02 The registrant shall disclose all scores according to the HVBP methodology, including achievement points and improvement points. The registrant shall consider the HVBP scoring methodology as a normative reference, thus any updates made year-on-year shall be considered updates to this guidance.
- .03 For its calculations, the registrant shall use HVBP scores after their weighting has been applied according to the HVBP methodology. Weighting is 45% for Clinical Process Domain scores, 30% for Outcome Domain scores, and 25% for Patient Experience Domain scores.
- .04 If applicable, the registrant shall indicate if any hospitals it operates have been excluded from the HVBP program for reasons enumerated under Section 1886(o)(1)(C)(ii), including those (i) subject to payment reductions under Hospital Inpatient Quality Reporting, or (ii) cited for deficiencies during the performance period that pose immediate jeopardy to the health or safety of patients, without the minimum number of cases, measures, or surveys.
- .05 The registrant may access many of the underlying data in a publicly available database via Hospital Compare, a service of Centers for Medicare & Medicaid Services.

NOTES

HC0301-01

Additional references:

Centers for Medicare & Medicaid Services, "[National Provider Call: Hospital Values-Based Purchasing](#)" July 11, 2012.

HC0301-02. Number of Serious Reportable Events (SREs) as defined by the National Quality Forum.

- .06 Serious Reportable Events (SREs) are identified by the National Quality Forum in a report entitled Serious Reportable Events in Health Care. There are [29 adverse events](#), classified under one of six categories (surgical, product or device, patient protection, care management, environment, or criminal), occurring in hospitals that are identified as “serious, largely preventable, and of concern to both the public and health care providers.”
- .07 The registrant shall disclose the aggregate number of such events that occurred during the fiscal year at the health care facilities it operates.
- .08 Where necessary to provide an accurate representation, the registrant should disclose SRE figures for individual facilities (e.g., if a small subset of facilities constitutes a disproportionate number of the SREs).
- .09 The registrant shall consider the National Quality Forum’s List of SREs as a normative reference, thus any subsequent updates to the scope or definitions shall be considered updates to this guidance.
- .10 The registrant shall disclose SREs occurring in any setting under its operation, including hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, and long-term care/skilled nursing facilities.

HC0301-03. Health care-acquired infections, as defined by the CDC’s National Healthcare Safety Network, for: (1) Central Line-associated Bloodstream Infections (CLABSIs); (2) Surgical Site Infections (SSIs); (3) Catheter-associated Urinary Tract Infections (CAUTIs).

- .11 The registrant shall disclose the number of health care-acquired infections (HAIs) – by type – that occurred during the fiscal year at facilities it operates for each of the following HAIs: CLABSIs, SSIs, and CAUTIs.
- .12 To identify and disclose HAIs, the registrant shall use methodology developed and maintained by the National Healthcare Safety Network (HNSN), the public health surveillance system operated by the Centers for Disease Control and Prevention’s (CDC) Division of Healthcare Quality Promotion (DHQP).
- .13 The registrant may use data on CLABSIs, SSIs, and CAUTIs that it currently discloses to meet the requirements of Centers for Medicare and Medicaid Services’ (CMS) Inpatient Quality Reporting Program, state-mandated reporting requirements, or otherwise reported directly to HNSN, insofar as they meet the other requirements of HC0301-3.

NOTES

HC0301-02

Additional references:

National Quality Forum, “[Serious Reportable Events in Healthcare 2006 Update](#).”

HC0301-03

Additional references:

Centers for Disease Control and Prevention (CDC) Division of Health Care Quality Promotion, “[National and State Health Care-Associated Infections Standardized Infection Ratio Report](#).”

HC0301-04. Excess readmission ratio for pneumonia, acute myocardial infarction, and heart failure, as defined by the Centers for Medicare & Medicaid Services (CMS). Readmissions Payment Adjustment Amount as part of the Hospital Readmissions Reduction Program.

- .14 Readmission shall be defined as an admission to a hospital within 30 days of a discharge from the same or another hospital, where hospital is defined by Section 1886(d)(1)(B) of the Social Security Act.
- .15 The registrant shall separately disclose the excess readmission ratios for pneumonia, acute myocardial infarction, and heart failure as a mean value for all hospitals it operates.
- .16 The excess readmission ratio shall be calculated as is defined by the Centers for Medicare & Medicaid Services (CMS), where the excess readmission ratio = risk-adjusted predicted readmissions/risk-adjusted expected readmissions.
- .17 The registrant shall follow all methodology described by CMS, including the use of three years of trailing data to determine excess readmission ratios for the current fiscal year.
- .18 The registrant shall disclose the Readmissions Payment Adjustment Amount—a reduction to the inpatient prospective payment system (IPPS) payments the registrant typically receives—in dollars, aggregated for all hospitals it operates.
- .19 The readmission payment adjustment amount shall be calculated as is defined by the CMS, where the Readmissions Payment Adjustment Amount = [Base operating diagnosis-related group (DRG) payment amount x readmissions adjustment factor] – base operating DRG payment amount.
- .20 The registrant shall consider the CMS’s IPPS Final Rules for each fiscal year as normative references, thus each annual update to the adjustment factors, definitions, methodology, and scope shall be considered an update to this requirement.

Access for Low-Income Patients

Description

Although the Patient Protection and Affordable Care Act (PPACA) will increase the number of insured individuals, the Congressional Budget Office estimates that 30 million nonelderly people will remain uninsured in 2023. The challenges associated with serving uninsured and low-income patients will be further compounded by reductions in Disproportionate Share Hospital (DSH) payments beginning in fiscal year 2014. Disclosure on efforts to extend services to uninsured populations and DSH allocations will allow shareholders to understand how companies in this industry are able to provide access to low-income patients and how serving the uninsured affects the business model.

Accounting Metrics

HC0301-05. Description of strategy to manage the mix of patient insurance status (i.e., private insurance, government insurance, and uninsured), including a description of alternative pricing mechanisms or programs for the uninsured.

- .21 The registrant shall describe its strategic approach to managing the impacts and effects of having patients with a mix of insurance statuses at its facilities. Where relevant, the registrant should discuss its approach to managing those patients with private insurance, government insurance, and those without insurance, and the risks and opportunities presented by each group.
- .22 Alternative pricing mechanisms include, but are not limited to, discounted/sliding fee schedules, care given for charity (as a write-off), or discounts for prompt payment for uninsured customers.
- .23 The registrant shall describe programs it implements for uninsured individuals including, but not limited to, financial assistance programs or participation in indigent care programs.

HC0301-06. Amount of Medicare Disproportionate Share Hospital (DSH) adjustment payments received.

- .24 The registrant shall disclose the amount of payment adjustment, in dollars, that it received through the Center for Medicare Services' (CMS) Disproportionate Share Hospital program in the form of increases to its basic Medicare Advantage diagnosis-related group (MA-DRG) payment.
- .25 The registrant shall disclose its payment adjustment as an aggregate figure for all eligible hospitals it operates.

NOTES

HC0301-05

Definitions: Indigent care programs – Programs typically administered by country or state governments that provide financial discounts for patients who demonstrate an inability to pay for health care services. Eligibility requirements may include proof of residency, an income at a fixed percentage (e.g., 250% or 250%) below the Federal Poverty Level (FPL), and ineligibility for programs such as Medicare, Medicaid, Children's Health Insurance Programs (CHIP), or state-administered insurance programs.

Financial assistance programs – Programs typically administered by hospitals that provide no-cost or discounted care for patients who demonstrate an inability to pay for health care services. Eligibility requirements may include proof of residency, an income at a fixed percentage (e.g., 250% or 250%) below the Federal Poverty Level (FPL), and ineligibility for programs such as Medicare, Medicaid, Children's Health Insurance Programs (CHIP), or state-administered insurance programs.

HC0301-06.

Additional references:

Department of Health and Human Services, "[Medicare Disproportionate Share Hospital – Rural Health Fact Sheet Series.](#)"

Employee Recruitment, Development, and Retention

Description

Health care delivery companies will face increased competition for physicians as the Patient Protection and Affordable Care Act increases demand and intensifies current and future shortages. The ongoing ability to recruit, develop, and retain health care practitioners is critical to success in this industry and disclosure on related performance indicators allows shareholders to understand how companies are managing a critical human capital factor in the health care delivery industry.

Accounting Metrics

HC0301-07. Employee turnover by voluntary and involuntary for: (1) physicians, (2) non-physician health care practitioners, and (3) all others.

- .26 Physicians include specialists and primary care physicians in the 29-1060 group of the Standard Occupation Classification (SOC) system from U.S. Bureau of Labor Statistics (BLS).
- .27 Non-physician health care practitioners include physician's assistants and nurse practitioners within the following groups of the Healthcare Practitioners and Technical Occupations ([29-0000](#)) Major Group of the SOC system from the BLS:
- 29-1070 Physician Assistants
 - 29-1080 Podiatrists
 - 29-1120 Therapists
 - 29-1140 Registered Nurses
 - 29-1150 Nurse Anesthetists
 - 29-1160 Nurse Midwives
 - 29-1170 Nurse Practitioners
 - 29-1180 Audiologists
- .28 For each category of employees the registrant shall calculate monthly voluntary turnover as = total number of employee-initiated voluntary separation (such as resignation, retirement, etc.) for each month divided by the average number of employees for the month (the sum of the employees on the registrant's payroll at each pay period / number of pay periods). The registrant shall disclose its annual voluntary turnover rate, calculated by adding the 12 monthly turnover figures together and multiplying by 100 to arrive at a percentage.

NOTES

HC0301-07

Additional references:

Society of Human Resources Management, [Executive Brief: Tracking Trends in Employee Turnover](#).

.29 For each category of employees the registrant shall calculate monthly involuntary turnover as = total number of registrant-initiated separation (such as dismissal, downsizing, redundancy, expiry of contract, etc.) for each month divided by the average number of employees for the month (the sum of the employees on the registrant's payroll at each pay period / number of pay periods). The registrant shall disclose its annual involuntary turnover rate which is calculated by adding the 12 monthly turnover figures together and multiplying by 100 to arrive at a percentage.

HC0301-08. Description of talent recruitment and retention efforts for health care practitioners, such as mentorship programs, flexible scheduling, and leadership development initiatives. Where applicable, participation or utilization rates for each type of effort.

.30 The registrant shall describe its strategy to attract and retain talent, including specific efforts related to mentorship programs, leadership development initiatives, flexible scheduling, part-time employment, "no call" positions, mental and physical health support, and loan repayment programs (e.g., specific to employment in underserved areas).

.31 It may be relevant to describe the following elements of programs: overview, implementation, participation, effectiveness (with any quantitative metrics).

.32 Health care practitioners include specialists, primary care physicians, physician's assistants, and nurse practitioners with the [29-0000](#) Healthcare Practitioners and Technical Occupations (Major Group) – Standard Occupation Classification (SOC) system from U.S. Bureau of Labor Statistics:

- 29-1060 Physicians and Surgeons
- 29-1070 Physician Assistants
- 29-1080 Podiatrists
- 29-1120 Therapists
- 29-1140 Registered Nurses
- 29-1150 Nurse Anesthetists
- 29-1160 Nurse Midwives
- 29-1170 Nurse Practitioners
- 29-1180 Audiologists

Pricing and Billing Transparency

Description

Currently more than half of all states require that hospitals report pricing information, and legislative trends suggest that a federal mandate is possible. Current and impending legislation, coupled with increased emphasis on health care cost containment, is likely to enhance scrutiny on the pricing and billing practices of companies in this industry. Firms that are able to achieve compliance and transparent pricing structures will be better positioned to protect shareholder value.

Accounting Metrics

HC0301-09. Description of policies or initiatives to ensure that patients are adequately informed about price before undergoing a procedure.

- .33 The registrant shall describe the nature, scope, and implementation of policies and initiatives focused on transparency and clear communication of the price of procedures and/or treatment alternatives insofar as they may be related to the price of a procedure.
- .34 Initiatives may include providing pricing information to consumers through written communication, posting information to a public website, or providing in-person consultation to consumers prior to services (e.g., during routine services as opposed to in emergency situations).
- .35 The registrant shall specify how information is provided to consumers paying out-of-pocket versus those with insurance coverage. For those with insurance coverage, this may include coordinating with the consumer's insurer to determine the amount paid out-of-pocket and the amount paid by the insurer.
- .36 The registrant shall specify if a precise total price, a range of prices, an estimate of price, or some other pricing information is provided to patients, such as the percentage (or amount) of the price for which the patient may be responsible.

HC0301-10. Describe how pricing information for services (including inpatient and outpatient) is made publicly available, including the number of the registrant's 25 most common services for which pricing information is publicly available, and the percentage of total services performed (by volume) that these represent.

- .37 The registrant shall describe the scope, format, and mechanism for making pricing information publicly available, such as via a public website and/or cooperation with government initiatives to consolidate pricing data.
- .38 The registrant shall discuss if information is available for inpatient services and outpatient services (occurring in any ambulatory setting such as a hospital, clinic, or physician office).
- .39 The registrant shall specify if it makes available a precise total price, a range of prices, an estimate of price, or some other pricing information

- .40 At minimum, the registrant shall identify the number of its 25 most common inpatient services and 25 most common outpatient service services for which it provides public pricing information, where most common services are the registrant's most frequently billed services by count of procedures conducted over the past three years (including the fiscal year).
- .41 The registrant shall calculate the percentage of total services for which there is publicly available pricing information by dividing the total number of procedures for which there is publicly available pricing information conducted during the fiscal year by the total number of procedures.
- The registrant shall perform this calculation for both inpatient and outpatient services.
- .42 If the registrant makes pricing for more than 25 of its inpatient or outpatient procedures publicly available, it should specify the number it makes available. The registrant may include this information in addition, as separate figures, to the data disclosed for .40 and .41.

Energy and Waste Efficiency

Description

The health care delivery industry faces significant costs associated with energy use and waste disposal. The Environmental Protection Agency's Energy Star Program estimates that hospitals spend \$8.8 billion on energy annually, accounting for 1–3 percent of a hospital's operating budget. Improved energy management and effective waste reduction strategies can lower operating costs and enhance shareholder value.

Accounting Metrics

HC0301-11. Total annual energy consumed (gigajoules) and percentage renewable (e.g., wind, biomass, solar).

- .43 The registrant shall convert the amount of electricity it purchased from kilowatt hours (kWh) to gigajoules (GJ).
- .44 The registrant shall disclose fossil fuel consumption in terms of its energy content, using higher heating values (HHV), also known as gross calorific values (GCV), and which are directly measured or taken from the Intergovernmental Panel on Climate Change (IPCC), the U.S. Department of Energy (DOE), or the U.S. Energy Information Administration (EIA).
- .45 The registrant shall disclose renewable energy consumption as a percentage of its overall energy consumption, in terms of its energy content. For biofuels, the registrant shall use HHVs from the sources mentioned above. For solar or wind energy consumption, the registrant shall convert from electricity production (kWh) to gigajoules (GJ).
- .46 The registrant shall disclose renewable energy data for renewable energy it either directly produces, or purchases through renewable energy certificates (RECs) that are certified (i.e., through Green-e) or through renewable power purchase agreements (PPAs). It shall not disclose the renewable portion of the energy that is drawn from electricity grids.

HC0301-12. Total weight of Regulated Medical Waste generation (as defined by the Medical Waste Tracking Act of 1988) and total weight by disposition (e.g., on-site incineration, landfill, treatment/storage/disposal facility, etc.).

- .47 Regulated medical waste (also known as medical waste, infectious waste, biomedical waste, or biohazardous waste), which may be subject to federal or state level regulation, shall be defined here according to the expired [Medical Waste Tracking Act of 1988](#) and includes:
 - Cultures and Stocks – Cultures and stocks of infection agents and associated biological cultures, including cultures from medical and pathological laboratories, and stocks of infectious agents from research and industrial laboratories, waste from the production of biological, discarded live and attenuated vaccines, and culture dishes and devices used to transfer, inoculate, and mix cultures.
 - Pathological Wastes – Human pathological wastes, including tissues, organs, body parts, and body fluids that are removed during surgery and autopsy, or other medical procedures, and specimens of body fluids and their containers.

- Human Blood and Blood Products – (1) Liquid waste human blood; (2) products of blood; (3) items saturated and/or dripping with human blood; or (4) items that were saturated and/or dripping with human blood that are now caked with dried human blood, including serum, plasma, and other blood components, and their containers that were used or intended for use in patient care, testing and laboratory analysis, or the development of pharmaceuticals. Intravenous bags are also included in this category.
 - Sharps – Sharps that have been used in animal or human patient care or treatment, or in medical research or industrial laboratories, including hypodermic needles, syringes (with or without the attached needle), Pasteur pipettes, scalpel blades, blood vials, needles with attached tubing, and culture dishes (regardless of presence of infectious agents). Also included are other types of broken or unbroken glassware that were in contact with infectious agents, such as used slide and cover slips.
 - Animal waste – Contaminated animal carcasses, body parts, and bedding of animals that were known to have been exposed to infectious agents during research (including research in veterinary hospitals), production of biologicals, or testing of pharmaceuticals.
 - Isolation wastes – Biological waste and discarded materials contaminated with blood, excretion, exudates, or secretions from humans who are isolated to protect others from certain highly communicable diseases, or isolated animals known to be infected with highly communicable diseases.
 - Unused sharps – The following unused discarded sharps: hypodermic needles, suture needles, syringes, and scalpel blades.
- .48 The registrant shall disclose the total weight of the waste generated in kilograms, aggregated for all facilities it owns and operates.
- .49 The disposition shall be identified, taken to mean the final destination of the waste, which may include on-site incineration, landfill, recycling facility, treatment facility, or other (e.g., return to a supplier, commercial composting, etc.).
- .50 If the registrant utilizes a waste transport service, broker, or intermediary to handle its regulated medical waste, it shall make a good faith effort to determine the final disposition.

HC0301-13. Total weight of pharmaceutical waste generation and total weight by disposition (e.g., on-site incineration, landfill, treatment/storage/disposal facility, etc.). Break down by: (1) hazardous waste and (2) non-hazardous (solid) waste.

- .51 The registrant shall calculate and disclose the total amount of each type of waste that is recycled (or reused), incinerated, and landfilled. If there are other dispositions for the waste (e.g., composting or permanent long-term storage), then the registrant should indicate so.
- .52 Pharmaceutical waste shall be broken down into two categories: (1) hazardous waste (listed RCRA waste and non-listed, characteristic hazardous waste) and (2) non-hazardous (solid) waste.
- .53 The registrant shall indicate the final disposition by each category of pharmaceutical waste, where the disposition may include on-site incineration, disposal at a specialized treatment or storage facility, recycling, landfilling, or another disposition.
- .54 If the registrant utilizes a waste transport service, broker, or intermediary to handle its regulated medical waste, it shall make a good faith effort to determine the final disposition of its waste.

NOTES

HC0301-13.

Definitions:

RCRA hazardous waste – waste that appears on one of the four hazardous wastes lists (F-list, K-list, P-list, or U-list) and found in regulation 40 CFR Part 261.

Non-RCRA hazardous wastes (characteristic wastes) – waste that exhibits at least one of four characteristics: ignitibility, corrosivity, reactivity, or toxicity.

Solid waste – any garbage or refuse, sludge from a wastewater treatment plant, water supply treatment plant, or air pollution control facility and other discarded material, including solid, liquid, semi-solid, or contained gaseous material resulting from industrial, commercial, mining, and agricultural operations, and from community activities. It may require special handling because it is a controlled substance, or poses an environmental or human health effect.

The U.S. EPA provides a [hazardous waste identification process](#). Should pharmaceuticals be added to an [expanded definition of Universal Waste](#), this requirement will be updated as appropriate.

Climate Change Impacts on Human Health and Infrastructure

Description

An increase in extreme weather events associated with climate change could present physical threats to health care delivery facilities and operations and create challenges in serving affected populations. In addition, these events coupled with the potential spread of infectious diseases, and food and water scarcity, are likely to present material implications for the health care delivery industry. Companies should subsequently disclose strategies to protect value in light of these challenges.

Accounting Metrics

HC0301-14. Description of the strategy to address the effects of climate change on business operations, physical infrastructure, and facility design. Discussion of specific risks (such as physical risks) presented by changes in the frequency and intensity of extreme weather and changes to the morbidity and mortality of illnesses and diseases.

- .55 The registrant shall discuss its strategic business approach to addressing significant risks presented by the changes in prevalence, geography, and severity of certain diseases that will be caused by climate change, such as:
- The need for added and/or flexible capacity due to influx of patients from climate-related events such as hurricanes, flooding, or heat related illness.
 - Obtaining the necessary facilities and expertise to identify and treat changing disease profiles in patients, such as for:
 - Malaria, dengue fever, and other vector borne diseases that affect tropical populations, but due to climate change may target non-tropical regions in the future;
 - Heat-related diseases (e.g., lung diseases such as asthma caused by increases in ground level ozone);
 - Waterborne diseases (e.g., cholera due to increased flooding incidence); and
 - Human developmental disorders (e.g., malnutrition due to decreased food availability).
- .56 The registrant shall discuss its strategic business approach to addressing the risks to physical infrastructure and assets presented by changes in the frequency, severity, type, and geographic location of extreme weather events such as:
- Risks to physical infrastructure that is located in low-lying and/or hurricane-prone areas.
 - Risks to physical infrastructure based on facility design, such as having key medical equipment in basements or lack of reliable backup power.

Fraud and Unnecessary Procedures

Description

Health care delivery companies are subject to significant fines and penalties under the Federal False Claims Act and similar state laws. Entities that receive at least \$5 million annually in Medicaid payments must have written policies for all employees and contractors regarding false claims, false statements, and whistleblower protections under these laws. The ability to ensure compliance in this area is likely to have material implications for health delivery companies.

Accounting Metrics

HC0301-15. Description of legal and regulatory fines and settlements associated with Medicare and Medicaid fraud under the False Claims Act. Dollar amount of fines and settlements and a description of corrective actions implemented in response to events.

- .57 The registrant shall briefly describe the nature and context of fines and settlements associated with Medicare and Medicaid fraud under the False Claims Act, including civil actions (e.g., civil judgment, settlements, or regulatory penalties) and criminal actions (e.g., criminal judgment, penalties, or restitutions) taken by any entity (government, businesses, or individuals).
- .58 The registrant shall disclose the amount of any fine or settlement associated with each incident, not including legal fees.
- .59 The registrant shall describe any corrective actions it has implemented as a result of each incident. This may include, but is not limited to, specific changes in operations, management, processes, products, business partners, training, or technology.

Patient Privacy and Electronic Health Records

Description

The Health Insurance Portability and Accountability Act (HIPAA) requires health care providers to establish administrative, physical, and technical safeguards to protect the integrity, confidentiality, and availability of patient health information. Failure to comply with these regulations can lead to civil and criminal penalties, while the American Recovery and Reinvestment Act (ARRA) has provided for enhanced enforcement and increased fines. The ARRA also established financial incentives for the meaningful use of electronic health records, as well as reduced Medicare payments for companies that fail to demonstrate meaningful use. Disclosure on HIPAA violations and electronic health records adoption will allow shareholders to monitor performance in these areas.

Accounting Metrics

HC0301-16. Percentage of patient records that are electronic medical records (EMR) or electronic health records (EHR) meeting the Centers for Medicare and Medicaid Services (CMS) “meaningful use” requirements.

- .60 The registrant shall calculate and disclose the percentage of records that are electronic health records (EHR) in “meaningful use,” as defined in [42 CFR \(Public Health\) Part 495 \(Standard for the Electronic Health Record Technology Incentive Program\)](#) and promulgated by the Centers for Medicare and Medicaid Services (CMS) as part of its EHR Incentive Programs.
- .61 EHR systems that are certified by an authorized testing and certification body according to the Office of the National Coordinator for Health Information Technology (ONC HIT) Certification Criteria shall be considered to meet the “meaningful use” requirements.
- .62 The registrant shall indicate which edition of the ONC HIT Certification Criteria its EHR systems are certified to, if not the most currently available.
- .63 Certified EHR systems are those listed on the [Certified Health IT Product List](#) (CHPL).
- .64 If the registrant does not participate in the Medicare or Medicaid EHR Incentive Program and/or its EHR is not listed on the CHPL, it may demonstrate through an independent audit that its EHR meets the threshold and all of the requirements for “meaningful use.”

NOTES

HC0301-16

Additional references:

Centers for Medicare and Medicaid Services, [“Introduction to the Medicare EHR Incentive Program for Eligible Professionals”](#)

The New England Journal of Medicine, [“Perspective: The ‘Meaningful Use’ Regulation for Electronic Health Records.”](#) August 5, 2010.

HC0301-17. Description of legal and regulatory fines and settlements associated with Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules violations or The Health Information Technology for Economic and Clinical Health (HITECH) Act violations. Dollar amount of fines and settlements and a description of corrective actions implemented in response to events.

- .65 The registrant shall briefly describe the nature and context of fines and settlement associated with Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules violations or The Health Information Technology for Economic and Clinical Health (HITECH) Act violations, including civil actions (e.g., civil judgment, settlements, or regulatory penalties) and criminal actions (e.g., criminal judgment, penalties, or restitutions) taken by any entity (government, businesses, or individuals).
- .66 The registrant shall disclose the amount of any fine or settlement associated with each incident, not including legal fees.
- .67 The registrant shall describe any corrective actions it has implemented as a result of each incident. This may include, but is not limited to, specific changes in operations, management, processes, products, business partners, training, or technology.

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