Instruction to Preliminary Supplemental Schedule of Population Health and Care Transformation Expenses

Instructions

Due date: Schedule should be submitted electronically via email to the HSCRC by 210 days after hospital year end for Fiscal Year 2021. (hscrc.annual@maryland.gov)

Schedule 1: Summary by Area

COLUMNS

Section 1, Regulated Hospital Entities Columns

Enter the name of each hospital in the system where "Hospital 1" etc. is populated in the template

For each regulated hospital, expenses should be populated in the appropriate column based on whether they were part of regulated or unregulated operations (see the instructions by row for the nature of expenses to include). Expenses allocated to a hospital from other entities and reported in the hospital's annual filing are considered hospital entity expenses for this reporting. The "Total Hospital" column is the sum of the regulated and unregulated.

Section 1, Health System, Non-Hospital Columns

Health system costs other than those expended by or allocated to regulated entities should be reported in the "Health System, Non-Hospital" columns. Expenses made by entities whose primary business is the operation of physician practices should be reported in the "Physician Practices" column. Expenses for all other entities should be reported in the "Other Entities" column. The "Total Non-Hospital" column is the sum of the "Physician Practices" and "Other Entities" column.

The goal of this report is to capture Maryland expenses. However, some health systems may have programs that serve multiple states and costs may not be separable. Therefore, the Health System should only include the full cost of a program if the amounts expended for the program are substantially focused on Maryland residents. In determining whether a program is substantially focused on Maryland residents a health system should consider factors like the number of participants by state, and what the cost of the program would be were it to only serve Maryland residents (i.e. if fixed costs of the program were not shared with other State's residents). If these metrics suggest the program is more than 60% focused on Maryland residents, then it would be considered substantially focused and the entire cost could be reported. If the program does not meet that that standard, the Health System should either exclude the program or report only the share of costs attributable to Maryland residents.

Section 1, Total CTI & Population Health for Health System Column

This column is the sum of the "Total Hospital" column for all hospitals in the system and the "Total Non-Hospital" column.

ROWS

Section 1, rows 1 to n: Direct Expenses, Non-Physician

In this section report Direct Expenses from Population Health and Care Transformation that are Non-Physician related as defined in the Definitions section of these instructions. The schedule has been pre-populated with some typical expense categories. These are defined further in the Definitions section of these instructions. These categories are provided as a guide but do not necessarily cover 100% of eligible expenses, additional rows may be added for expenses that meet the definition provided for this section but do not fit into one of the pre-populated rows.

Section 1, row 1T:

This row is the sum of all rows in Section 1 above

Section 2, Direct Expenses, Physicians/Physician Extenders

In this section report Direct Expenses for Physicians and Physician Extenders (Physician Direct) as defined in the Definitions section of these instructions. Expenses should be organized into the rows described below. In section 6 of the report hospitals are asked to describe the physician specialties included in each of the rows in Section 2. The specialties for each row in section 2 should be identified separately, a single consolidated list is not sufficient.

Section 2, Row 1: Hospital Coverage

In this row report Physician Direct expenses that related to providers who are essential to the operation of a regulated hospital and are being compensated for work that occurs in that hospital. Examples include hospitalist costs and on-call fees paid to specialists to provide emergency department coverage.

Section 2, Row2: Population Health focused clinics

In this row report Physician Direct expenses for providers who work in a clinic operated by the health system that was founded specifically to manage population health in a creative or innovative way by enhancing care of filling unmet needs for specific populations. Traditional hospital clinics or acquired primary care practices should not be included in this row.

Section 2, Row 3: Community Physicians in specialties identified in CHNA

In this row report Physician Direct expenses for providers who work in a traditional clinic or practice in a specialty that was cited as a needed specialty in the Hospital's Community Health Needs Assessment (CHNA) for the appropriate reporting period.

Section 2, Row 4: Community Physicians - Primary Care, not in CHNA

In this row report Physician Direct expenses for providers who work in a primary care clinic or practice if primary care was not included as a needed specialty in the Hospital's CHNA for the appropriate reporting period (if primary care was identified in the CHNA this row should be zero for that hospital).

Section 2, Row 5: Community Physicians - All Other, not in CHNA

In this row report Physician Direct expenses for providers who work in specialties other than primary care that were not included as a needed specialty in the Hospital's CHNA for the appropriate reporting period.

Section 2, row 2T:

This row is the sum of all rows in Section 2 above

Section 3 is not used

Section 4, rows 1 to 5: Indirect Expenses, Physician Related

In this section report Indirect Expenses from Population Health and Care Transformation that are Physician related as defined in the Definitions section of these instructions. These expenses should be mapped into the same categories as Section 2 based on the nature of the physicians they support. Costs that are not specific to one category of physicians should be allocated based on relative cost or some other reasonable basis.

Section 4, row 4P:

This row is the sum of all rows in Section 4 above.

Section 4, row 4T:

This row is row 4P expressed as a % of row 2T

Section 5, Rows Phy1 to Phy5: Related Revenue – Physician Revenue – (these amounts should not be reported as a negative adjustment. Please enter as a positive number, unless it is a loss).

Report the revenue received by the relevant entity from billing for the physician services reported in Section 2, rows 1 to 5. The revenue should be reported net of deductions. The revenue for any physician reported in the regulated entity columns (regulated or unregulated) should tie to the revenue amounts reported in the hospital's annual filing.

Section 5, Row 5T-Physician: Total Physician Related Revenue

This row is the sum of all rows in Section 5 Physician above

Section 5 Rows Oth1 to Othn:

Report any funding, other than through the hospital's global budget that supports the non-physician expenses reported in Sections 1 and 3. Hospitals may group revenue sources into logical buckets and add additional rows as needed. Example of funding to be reported in this section include care management fees received under the MDPCP program or other programs, grant revenue from HSCRC or other grants, patient fees, local government funding or charitable contributions or corporate sponsorship if it was designated to support the expense in question. Any patient revenue reported should be reported net of deductions.

If expenses are reported in sections 1 and 3 that have a related revenue source it must be reported in this section.

Section 5, Row 5T Total Related Revenue

This row is the sum of row 5T-Physician and row 5T-Other Revenue.

Section 6: Descriptive Information for Section 2

In each row of this section provide a written list of the specialties or other description of the nature of the physicians included in the equivalent row in Section 2. Each row in section 2 should be addressed separately.

Section 7 is not used

Section 8: Other Discussion/Commentary

Please use this section to discuss the assumptions and distinctions made in completing this report. Highlight any areas where definitions were unclear or problematic. This information will be used to refine and improve the reporting requirements in time for FY2022. Feel free to attach a separate document with this commentary if that is easier.

Schedule 2: Reconciliation to Annual Filing

This schedule breaks out sections 1 and 2 on Schedule 1 by the cost center on the Annual Filing in which regulated enitity expenses shown on Schedule 1 were reported. As such this schedule is not applicable to health system expenses reported in the Health System, Non-Hospital columns on Schedule 1.

COLUMNS

Section 1, Regulated Hospital Entities Columns

Enter the name of each hospital in the system where "Hospital 1" etc. is populated in the template

For each regulated hospital expenses should be populated in the appropriate column based on whether they were part of regulated or unregulated operations (see the instructions by row for the nature of expenses to include). Expenses allocated to a hospital from other entities and reported in the hospital's annual filing are considered hospital entity expenses for this reporting. The "Total Hospital" column is the sum of the regulated and unregulated.

ROWS

Section 1, Rows 1 to n: Direct Expense Non-Physician

In this section report Direct Expenses from Population Health and Care Transformation that are non-Physician related as defined in the Definitions section of these instructions. Expenses should be organized into by the cost center in which they were reported in the hospital's Annual Filing (e.g., Management on Schedule C or Malpractice on Schedule UA). The Schedule is pre-populated with the frequently used cost centers, but additional rows may be added if additional cost centers are referenced. Expenses should be reported in the cost center where they were recorded prior to any allocations within the Annual Filing. The individual amounts in each cost center should just be those reported in Schedule 1 that were reported in that cost center on the Annual Filing They will not tie to the total reported on the Annual Filing for that cost center. The goal of this section is so that, when combined with the Annual Filing, the HSCRC can calculate the % of a given cost center in the Annual filing that is reflective of population health costs.

Section 1, row 1T:

This row is the sum of all rows in Section 1 above. This amount should agree to the amount shown in row 1T for the equivalent column on Schedule 1.

Section 2, Direct and Indirect Expenses, Physicians/Physician Extenders

In this section report Direct and Indirect Expenses for Physicians and Physician Extenders (Physician Direct) as defined in the Definitions section of these instructions. Expenses should be organized into by the cost center in which they were reported in the hospital's Annual Filing (e.g. URx).

Section 2, row 2T:

This row is the sum of all rows in Section 2 above. This amount should agree to the amount shown in row 2T + 4T for the equivalent column on Schedule 1.

Definitions

Direct Expenses from Population Health and Care Transformation that are Non-Physician

Expenses in this category reflect the expenses incurred in directly delivering eligible services as described below including both labor and materials. The discussion below reflects the HSCRC's thinking regarding what should be included. Due to the wide variety of costs and situations Hospitals should use their judgement in what they include.

Eligible Services

Eligible services include any service provided by a health system that meets all of the following:

(1) Do not meet the definition of Physician Expenses as defined below and
(2) Are not the delivery of traditional hospital services or incidental activities that commonly accompany the delivery of traditional hospitals services
(3) The health system receives no or nominal reimbursement under insurance or through grants or other revenue sources (see discussion below). Note this does not preclude reporting as population health expenses tangible, additional services that are provided in conjunction with a reimbursed services but are beyond what that reimbursement would generally be expected to cover. For example, a hospital maintains a staff of social workers who provide community outreach in a Health Aging clinic and their services are not billed separately. The cost of the social workers would be Eligible Services although the traditional clinic services would not be.
(4) Are intended to either (1) promote the health of the community more broadly or (2) improve the well-being of and care delivered to an individual outside the hospital in a way that traditional hospital or physician care does not.

Default Eligible Service Categories Provided in Section 1

Section 1 includes some predefined categories; further explanation of each category is provided below. These categories are provided for reporting convenience and are not intended to be an exhaustive list. Costs must meet the overall definition of Eligible Services above to be reported regardless of the category definition. Costs that meet the definition of Eligible Services but do not fit in one of the predefined categories should be reported in the "other" line or by adding additional lines with new categories.

Population Health Administration: Administrative and management costs of operating population health initiatives. Dedicated support functions like an analytics or finance team should also be included in this category.

Workforce Development: Programs that create/enhance population health related workers.

Care Management: Programs that provide community-based and transitional care management, either in person, or via telemedicine, that go beyond traditional discharge planning to enhance outcomes through appropriate ongoing community-based or post-acute care.

Communications: Programs that provide public information regarding population health (should not include general brand marketing or marketing of billable services).

Home Health Support: Programs that provide home health services beyond those which are reimbursed under traditional home health reimbursement.

Preventive Care: Programs to (1) increase the use of preventive care or (2) for preventive services that are not otherwise reimbursed.

Telemedicine: Program to deliver telemedicine services that are not otherwise reimbursed.

Community Outreach: Spending on community health workers, outreach workers, community education and other community-based resources with the specific goal of averting future healthcare spending.

Population Health Clinics: Non-reimbursed, Non-physician related spending on clinics (mobile or otherwise) that increase access to primary or specialty care and/or provide services beyond those normally available in a typical office care setting. For example, embedding social workers within a primary care clinic.

Housing: Programs that seek to improve access to quality housing in order to avert future healthcare spending.

Food: Programs that seek to improve access to food in order to avert future healthcare spending.

Transportation: Programs that seek to facilitate patient transportation in order to avert future healthcare spending.

Reimbursed Services

Under the limitation in item 3 of the Eligible Services definition above, a hospital may not report in this schedule losses on services such as home health or skilled nursing as these services have substantial reimbursement through an existing revenue stream. However, there is an exception to this rule if both of the following is true:

(1) the reimbursement received is less than 60% of the cost of the service and
(2) the incremental, tangible services driving the net loss cannot be isolated and reported as in the Social Work example cited under Eligible Services.

In this case the entire cost of the services would be reported in Section 1 and the revenue would be reported in Section 5. Example of this exception might include:

- an outreach program that is 20% grant funded.
- if the Nurse Practitioners in a Healthy Aging clinic were held to a lower than normal productivity standard to allow them to perform home visits and take extra time with patients and family resulting in overall net losses on their services.

Management Costs

Management costs should only be considered direct to the extent a supervisor or manager is dedicated or substantially dedicated to the population health activities. For example, the supervisor of a community outreach team would be considered Direct as would a Vice President of Population Health. But time allocated to Population Health by managers with broader responsibilities should be included under indirect expenses.

Allocation of Costs

Direct expenses other than management costs may be based on an allocation to the extent that the involved costs supporting the reported population health activity are shared with other services. For example, a hospital maintains a call center that both confirms hospital appointments and performs patient education follow-up post discharge. Only the latter is considered an eligible service, therefore the cost of these employees should be allocated based on a relevant unit, e.g. number of calls or time on calls for each subject. Note, confirming hospital appointments is not consider a population health cost for this schedule because it is connected to the delivery of a traditional hospital service (see item 2 under the eligible service definition)

Direct Expenses for Physicians and Physician Extenders (Physician Direct)

Expenses in this category reflect the expenses incurred to engage physicians to provide care. To simplify reporting the HSCRC is deeming all physician costs Population Health for the purpose of this section of this schedule therefore all physician costs should be reported in this section regardless of the nature of the services provided except for residents and intern costs (see below).

Physician should be defined to include physicians and other practitioners who may practice independently (e.g. Nurse Practitioner, Physician Assistant, Social Workers in the behavioral health space). The cost should only be the actual cost of the physicians acting as providers, as follows:

1. It should only include the direct cost of the physician – i.e. salary (including all bonuses) and fringe benefits for employed physician and fees paid to non-employed physicians.
2. It should not include other costs of physician clinics such as medical assistants and reception (that should be reported in Indirect).
3. It should not include the cost of physicians acting in management roles or other administrative, those should be reported in the appropriate location based on the nature of the role.

4. It should not include direct or indirect resident and intern costs as they have separate reimbursement streams and are not considered population health for the purpose of this report.
5. For a regulated entity it would include costs reported in schedule's P1, P2, P3, UR6 and UR8 of the hospital's annual filing. If physicians who otherwise meet this definition are reported in a different schedule they should be excluded from this section and discussed in section 8.

Indirect Expenses from Population Health and Care Transformation, Physician

In this section report expenses related to the physicians reported in section 2, other than the cost of the physicians themselves (which would be reported in Section 2).

Regulated Entities

For a regulated entity the indirect costs can be calculated from the hospital Annual Filing as follows:

> Regulated - The sum of schedule P1, P2 and P3, line B, Column 4 less the amount reported as Physician Direct
>
> Unregulated – The sum of schedule UR6 and UR8, line F, column 3 less the amount reported as Physician Direct

Some hospitals report expenses net of related revenue within the UR schedules of their annual filing. While this is acceptable for the annual filing, expenses should not be reported net in this report. Revenue should be separately identified in section 5. If net reporting is used in the annual filing then the regulated and unregulated calculations above should be adjusted to first add back the revenue in calculating the amounts from schedules annual filing schedules.

Unregulated Entities

For physicians services recorded outside the regulated entity and therefore not reflected in the annual filing this section should include the equivalent costs to those captured in the annual filing. For example labor, technology, management and space costs to maintain the practice where the physicians operate. Either dedicated or allocated Senior Management costs related to operating physician practices may also be included.