maryland health services cost review commission

ANNUAL FILING MODERNIZATION PROJECT
CLINICIAN COST SCHEDULE

FREQUENTLY ASKED QUESTIONS

(as of September 10, 2025)

1 Q. Where should we report off-setting revenue for Medicaid MCOs?

A. Medicaid MCO revenue data should be reported in the Medicaid bucket on Tab 1D.

2 Q. Where should pediatric surgical and non-surgical specialty data be reported?

A. Pediatric information should be reported in the associated adult surgical and non-surgical categories. There are two specific pediatrics categories included in the MGMA specialty list: **Pediatrics: Adolescent Medicine** and **Pediatrics: General**, both of which are in the primary care category.

3 Q. How will the data collected through the CCS be used? When will it matter to hospitals?

A. Our proposed approach and timeline is shown in the table below.

Phase	Initial Design	Feasibility Testing		Annual Filing Integration		
Work Product	Scope and Approach Survey	Supplemental Schedule V.I	Supplemental Schedule V.II	Annual Filing, including Clinician Cost	Annual Filing, including Clinician Cost	Annual Filing, including Clinician Cost
Data Reporting Period	**FY 2023**	**Q1 & Q2 2024**	**FY 2024**	**FY2025**	**FY2026**	**FY 2027**
Rate Setting Stages	Submitted Clinician Cost data not considered in any GBR Rate-setting Analysis				Clinician Cost considered in Rate- Setting Policy	First possible effect on GBR Rates seen

4 Q. Is the scope of the Schedule to only capture clinician costs that are reported in each entity's Annual Filing? Example: An organization employs clinicians throughout the health system. Some clinicians are directly employed by the hospital while others are community providers that are subsidized by the hospital. In addition, there are clinicians employed at the system level that don't directly financially impact any rate regulated entity. How would the HSCRC like this information reported in the Schedule?

A. The scope of the CCS is NOT limited to only those clinician costs that are currently reported in the annual filing. The scope of the schedule is to capture ALL clinician (physicians and advanced practice providers) costs for which the hospital is financially responsible.

There are three primary tabs (1a, 1b, and 1c) which cover the basic business relationships between the hospitals and clinicians.

1. Tab 1A - Clinicians Employed by Hospital in the workbook is for reporting clinician costs for providers employed by the hospital

2. Tab 1B - Independent Clinicians/Clinician Groups Contracted by Hospital

3. Tab 1C - Clinicians/Clinician Groups Contracted via Related Party Entity (RPE)

Tabs 1B and 1C may contain direct payments as well as payments to contracted clinicians whose Part B reimbursements are supplemented by the hospital as subsidies or stipends In the FY 2025 CCS, the cost of Hospital Administration services performed by a Clinician are to be included within "Regulated" services.

To the extent that payments to clinicians by related entities are made in connection with hospital services or service to hospital patients, they would fall under the scope of the CCS (Tab 1C). To the extent that the hospital is obligated to fund system management fees or allocations which include related entity payments to clinicians, that portion of the management fee or allocation payment related to payments to physicians would also be within the scope of the Clinician Cost Schedule (Tab 1C).

5 Q. **What is the purpose of Schedule 1D Payor mix?**

A. Data for Schedule 1D Payor Mix is being requested in order for the HSCRC to better understand the impact of varying professional fee schedules among the payers. This was created in light of a comment raised by a hospital during one of the workgroup meetings regarding professional fees and their varying impact on hospitals depending on payor mix.

6 Q. **Schedule1D Payor Mix. How should hospitals report data on this schedule for which they don't know the payor mix? For example, a hospital has agreements with a related entity which collects offsetting professional fee net revenues for patient services rendered by physicians working under employment or contractual arrangements with the hospital. Under this arrangement between the hospital and the related entity, the related entity remits the collected offsetting professional fees to the hospital. However, the associated payor mix data for those remitted collections has not been provided to the hospital.**

A. Hospitals should report information on this schedule for all clinician services for which the payor mix information is available. To the extent that payor mix information is not available, that piece of information should not be estimated or reported.

The HSCRC is evaluating alternative estimations of payor mix as a short-term measure. Over the long-term, staff will encourage each hospital to incorporate in its contractual agreements, the capture and reporting of payor mix data for offsetting professional fee net revenues collected by a third party and remitted to the hospital.

7 Q. **Should residents be included?**

A. In the FY 2025 CCS, Resident costs should be reported on schedule 1E. This data should agree with the Hospital's Annual Filing (Schedules P4, P5, and P6).

8 Q. **Schedules 1A, 1B, and 1C Can the HSCRC please define how outpatient clinic physician expenses provided through regulated clinics should be reported/not reported?**

A. Because the clinic is in the hospital and regulated, outpatient clinic physician expenses provided through regulated clinics should be reported by the hospital as "Regulated Service".

9 Q. **How should hospitals report unregulated, inpatient facilities "at the hospital" (e.g., the hospital has an unregulated, inpatient SNF)?**

A. For unregulated, inpatient facilities that are still under the control and obligation of the hospital, this information should still be reported. For the example with the SNF, the clinician time and expenses should be reported under “Unregulated Service”.

10 Q. **Should contract fees paid to contracted Clinicians be reported separately from related offsetting net revenues received by the hospital?**

A. In FY 2025, CCS has been designed for reporting contract fees and offsetting revenues separately by specialty.

- Where separate reporting is not currently feasible, combined net reporting as contracted fees should be used by specialty.
- If the level of reporting noted above is also not feasible, please reach out to the HSCRC.

11 Q. **If a community practice, not owned or supported by the hospital, incurred a net loss for the period, should the loss be reported?**

A. If the hospital or its subsidiary does not own and has no direct or indirect obligation to support the practice, it should not report the loss.