maryland health services cost review commission

ANNUAL FILING MODERNIZATION PROJECT
CLINICIAN SUPPLEMENTAL SCHEDULE

FREQUENTLY ASKED QUESTIONS

(as of July 29, 2024)

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. For some related party providers, the amount accrued and/or paid from July through December might not equal the amount that a hospital ultimately owed for that time period. For instance, in some cases hospitals aren't billed, or don't calculate, what they owe until the following few months. Should these numbers match the payments plus accruals in the general ledger as of December 31, 2023?

A. This draft of the Supplemental Schedule has been circulated outside the normal timing of the Annual Filing. We understand, therefore, that determining final accrued costs may not be fully or easily feasible. We would ask for you to use a "most reasonable estimate of any accruals" for this test response of the Supplemental Schedule.

When the Supplemental Schedule is finally adopted during next fiscal year, the timing for issuance will match that of the full Annual Filing and therefore you will be able to reference those yearend results and accrual estimates that will tie to your audited financial statements.

4 Q. How will the data collected through the Supplemental Schedule 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

5 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 clinician cost supplemental schedule 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 Additionally, Tab 2 contains hospital administration costs. Most, if not all, of these costs may be reported in a hospital's annual filing.

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 Supplemental Schedule (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 Supplemental Schedule (Tab 1C).

6 Q. **What is the purpose of 'C. Schedule 2 Admin'?**

A. The intended purpose of 'C. Schedule 2 Admin' in the supplemental schedule is to collect data for both the time spent/designated and the associated compensation related to each hospital's use of Clinicians who serve in Hospital-wide management and administrative roles. This use of Clinicians is distinguished from Departmental Admin and Supervision roles covered in C. Schedules 1A, 1B, and 1C.

7 Q. **Can the HSCRC provide an example of how to report information between Schedules 1A, 1B, and 1C and Schedule 2?**

A. Let's use the example where a hospital has a CMO who is a Board-certified immunologist. This CMO does not see patients and their salary is paid directly by the hospital. The FTEs and compensation associated with the time spent practicing as an immunologist would be reported on C. Schedule 1A row 8 in Columns E and K, respectively.

For C Schedule 2 Admin, the hospital should report that it has a CMO that is employed by the hospital (Column A) and the FTEs and compensation associated with the time spent as the CMO should be reported in Columns D and E, respectively.

In this case, the Clinician is not seeing patients so their FTEs and compensation should be reported on C. Schedule 2 Admin. For Clinicians who split their time between seeing patients and hospital administration, the FTEs and compensation should be allocated to each appropriate

schedule. If the FTEs and compensation for hospital administration cannot be separately identified, the FTEs and compensation on C Schedule 2 Admin should be reported as 0.

The combined reporting of FTEs and compensation between C Schedules 1A and 2 Admin should equal the immunologist's total FTE and compensation.

8 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.

9 Q. **Should Schedule 1D Payor Mix include information about Schedule 1A Clinicians? They are not included in the formula that checks if the data matches to information already provided in earlier schedules.**

A. This is an oversight on the part of the HSCRC. As the tab is locked for editing, this is unable to be changed by the hospitals. Please input the information being sure to include information about Clinicians included in Schedules 1A, 1B, and 1C. This may not match the information provided by the validation check formula.

10 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.

11 Q. **Schedule 3 Benefits. Background: The hospital participates in a system-wide allocation of employee health Insurance expenses. The allocation is made based on a system-wide methodology. The system's expense allocation to each hospital is made on an annual basis. The amount allocated differs from the total costs of the hospital's eligible employee claims amount. How should the hospital report this expense for the Supplemental Schedule?**

A. This Supplemental Schedule has been issued as a test of data gathering feasibility and reporting adequacy. Our intention is to use the comments, questions, and requests of the hospital industry as opportunities to improve the structure and content of the future versions of the Schedule. In completing this Supplemental Schedule, we request that you use the same estimated expense incorporated into the hospital's associated financial statements.

12 Q. **Schedule 3 Benefits. Background: FICA benefits are paid on a calendar year basis, with a greater amount paid typically in the early months compared to later months. Using FICA paid year-to-date as expense will cause an understated expense in the July 1 to December 31 reporting period. How should this be handled?**

A. Because this Supplemental Schedule has been issued as a test of data gathering feasibility and reporting adequacy, we recommend hospitals report the FICA Benefits based on the amounts calculated by their payroll systems and incorporated in their referenced financial statements for the period.

This over/under statement should go away when we begin to issue the final adopted Supplemental Schedule which will be issued in conjunction with your yearend and related Annual Filing timeline.

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

A. No. We believe the reporting required by the current Annual Filing is adequate.

14 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 “Physician In-Hospital Service”.

To clarify this matter, we intend to revise our definition of Physician In-Hospital Service to “…treatment of identifiable patients in regulated services at the hospital”.

15 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 “Community Practice”.