Maryland Institute for Emergency Medical Services Systems

Maryland Health Care Commission

Options for Modernization of the Trauma Physician Services Fund

Maryland Commission on Trauma Funding

September 29, 2023

Meeting #2 Agenda

- Welcome and Introductions

- Trauma Center Experience in the US and Maryland – Parallels and Differences
  Raymond Fang, MD, FACS
  Chair, Maryland ACS Committee on Trauma
  Chair, Maryland Trauma Center Network

- Impact of the Maryland Total Cost of Care Model on Trauma Services and Reimbursement –
  Cait Cooksey, Deputy Director, Hospital Rate Regulation, HSCRC

- Discussion – Current Framework of Payment Streams of the Maryland Trauma Physicians Fund:
  a) On-Call
  b) Uncompensated Care
  c) Medicaid - Underpayments
  d) Equipment Grants
  e) Opportunities to utilize surplus

5) Next Steps

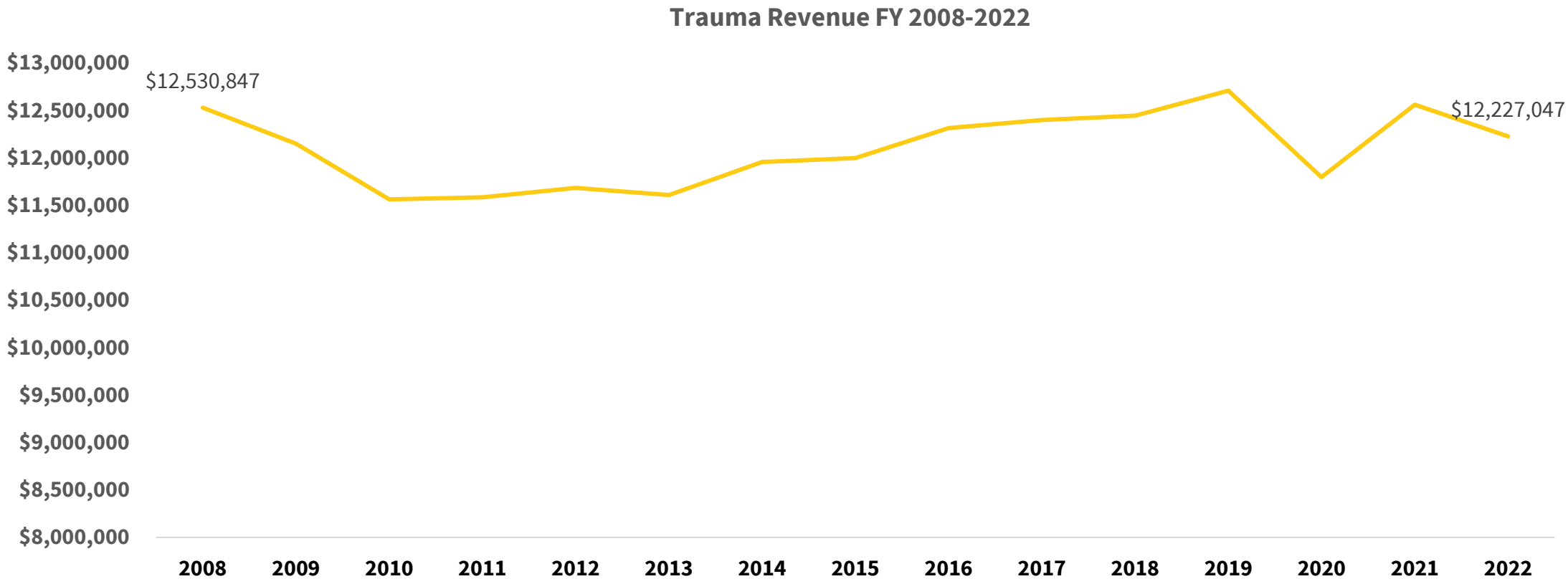
Trauma Physician Services Fund

- The defined distribution formulas are defined in statute:

  Review of Funding Streams:

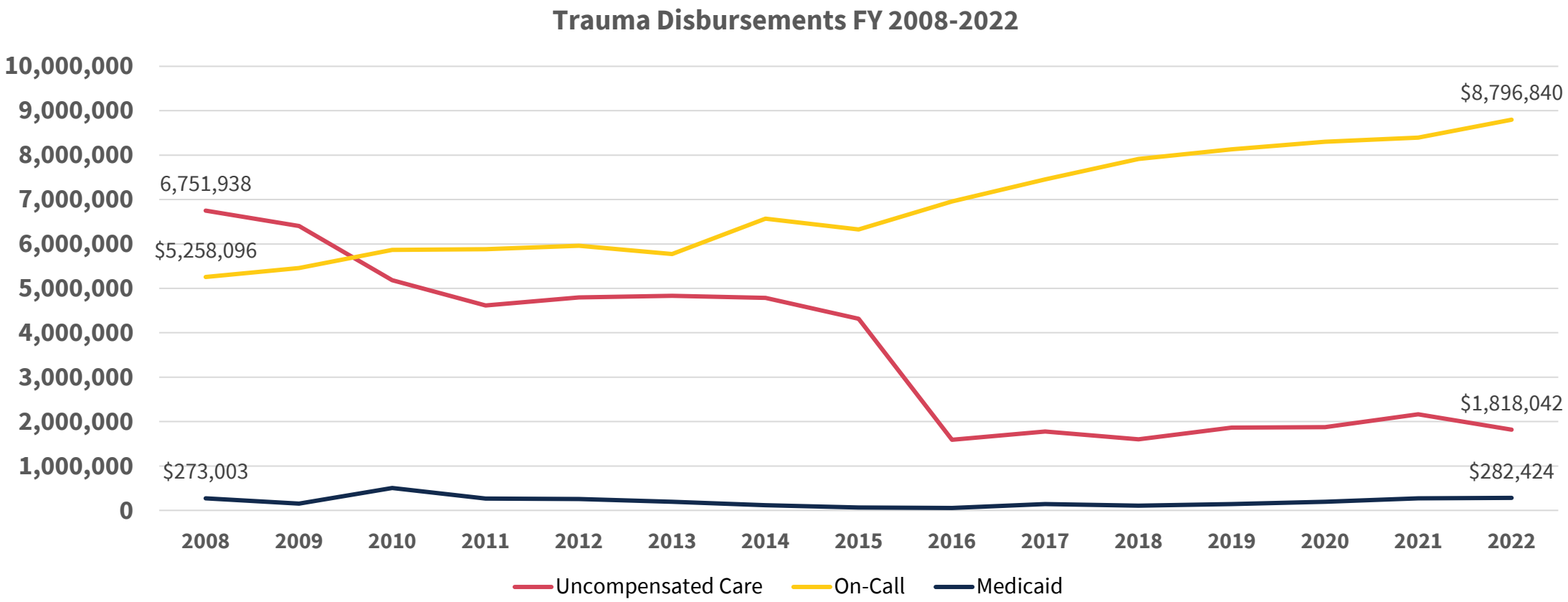
  1) On-call paid to hospitals for documented availability costs for trauma physicians, anesthesiologists, neurosurgeons, and orthopedists at Level III centers and to trauma surgeons, neurosurgeons and orthopedic surgeons at Level II centers.
  2) Uncompensated care paid to practices that deliver trauma care,
  3) Trauma equipment grants awarded biannually to Level II and III centers,
  4) Medicaid supplemental payments paid to practices that deliver trauma care,
  5) Standby stipends included in HSCRC-approved hospital rates at PARC, Level I & II Centers.

Trauma Revenue Collected from Registrations and Renewals



Source: MHCC analysis of MVA revenue reports 2008-2022

Trauma Disbursements by Funding Type



Source: MHCC analysis of Trauma Payments 2008-2022

Increase Fund Flexibility

MHCC and HSCRC, the administrators of the Fund, have limited flexibility to balance funding based on available trauma needs and reserve levels.

- Option 1 – Removing funding formulas from statute and implement in regulations.
  - New framework would allow for greater flexibility
  - Fund administrators would need time to adopt regulations
- Option 2 -- Keep existing formulas in statute, allow Fund administrators to spend down existing balances through annual distribution of some reserve funds based …
  - Stress and capacity,
  - Equipment needs, or
  - Other criteria
  - Note surplus fund might not exist every year.
- Option 1 would assume periodic adjustments in regulations, which might provide greater predictability than Option 2. Option 2 would allow flexibility to respond to changing needs.

Allowing Administrators to Rebalance Funds May Allow for Modest Funding Increases

Reserves in 2020 and 2021 were only $2 million

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	FY 2020	**FY 2021**	**FY 2022**
Fund Balance at Start of Fiscal Year	$3,906,147	$2,085,101	$2,171,071
Collections from the $5 Registration Fee	$11,798,484	$12,562,282	$12,227,047
Credit Recoveries	$161,748	$52,527	$70,872
Addition from the 2022 Budget and Reconciliation Financing Act Legislation	($0)	($0)	**$4,000,000**
TOTAL (Balance, Collections, and Recoveries)	**15,866,350**	**$14,699,910**	**$18,468,990**
TOTAL (Payments, Grants and Expenses)	**($13,781,279)**	**($12,528,839)**	**$11,768,157**
TRAUMA FUND BALANCE	**$2,085,101**	**$2,171,071**	**$6,700,833**

Change On-call Formula

In statute, hospitals are eligible for reimbursement for on-call stipends paid to four specialties. Reimbursement is derived from a reasonable compensation equivalent (RCE) formula used by CMS to reimburse non-PPS hospitals. The RCE formula is updated annually by a component of the Medicare Economic Index.

- Option 1: Increase the number of specialties eligible for on-call.
  - Subsidies on on-call stipends could lead to more on-call requests from other specialties
  - Is the level of call response sufficient to warrant a subsidy?
- Option 2: Increase the level of on-call funding to existing designated specialties
  - Increasing subsidies could accelerate physician requests for even higher on-call stipends.
  - Are higher pass-through payments warranted for employed physicians?
- Other considerations
  - MHCC estimates that any increases in the specialties eligible or the level of reimbursement would require an increase in the $5 biannual assessment on registrations and registration renewals.
  - On-call is only paid to Level II, Level III, and some specialty trauma centers, adding funding will spark request from higher standby subsidies from Level 1 and PARC, which are paid through HSCRC rates.
  - RCE formula is no longer used by CMS, but it is serviceable because it can be update by a recognized inflation factor.

Broaden and Redefine (Equipment) Grant Funding

Fund administrators award trauma equipment grants biannually. Total grant funding is limited to 10 percent of the existing reserve. This amounts to from $200,000 to $600,000 in total grant funding.

- Option 1: Remove cap on the percent of the Fund reserve that can be committed to equipment grants.
  - Provides a simple mechanism to balance the fund
  - Once the reserve is depleted, risk of Fund insolvency would rise. These options would likely reduce the reserve in one year and move grant funding back to current levels in following years.
- Option 2: Broaden the grant funding to cover financial stress in trauma center and allow the hospitals more flexibility on how funds could be used.
  - Is preferable to a grant process that narrow targets equipment
  - Same challenges apply as Option 1.
- Other considerations
  - A long-term expansion of grant funding will require an increase in the annual assessment.

Expand Medicaid Underpayment Rules

Medicaid underpayments have been modest throughout the existence of the Fund. Medicaid reimburses for trauma services at 100% of Medicare rates applying Medicaid adjudication rules. MCOs responsible for most payments and most reimburse for trauma care close to Medicare rates. Differentials are small.

- Some trauma providers argue that the multiple procedure should be waived for trauma claims. Complex trauma cases often involve multiple procedures on gravely injured patients. Given the complexity of the cases, a multiple procedure reduction is not justified. The multiple procedure adjustment rule reimburses a provider at 50% of the regular rate for the second and subsequent procedures. If the second and subsequent procedure were reimbursed at 100 percent of Medicare, as is done with uncompensated care, the impact to the Fund could be significant. In those surgeries, the Fund would have to pay the difference between 100 percent of Medicare and 50% of the Medicare Fee for second and third procedures.
- In the past Medicaid has opposed modifying the multiple procedure reduction because changing adjudication rules in the software of multiple MCOs would cumbersome.
- An alternative would be to raise Medicaid rates for trauma services to more than 100% of Medicare for all trauma claims. The multiple procedure reduction would continue.

Next Steps

- Schedule Next Meetings

  - Meeting # 3 (target Mid-October ?)

  - Meeting #4 (November ?)

- - Topic Meeting 3: Opportunities for Expansion
  a) Trauma Center Cost Analysis and Unmet Trauma Needs
  b) Options for Increasing Trauma Fund Revenue
  c) Options for Increasing Trauma Funding outside of the Fund