Commission to Study Trauma Funding

MHCC Proposed Recommendations Ideas

to the

Maryland Trauma Physician Services Fund

A. Recommendations Pertaining to HSCRC's Authority to Establish Hospital Rates

1) All allowed hospital trauma costs should be included in hospital rates.
   Physician standby costs, other clinician costs, trauma center staff expenses, and trauma center administration costs are allowable hospitals costs.

   HSCRC should continue to include costs already included and should *consider* adding the costs that are currently not incorporated. Information on trauma costs should be provided in a transparent manner.

2) HSCRC should study the feasibility of allowing trauma center hospitals to bill trauma activation fees *in lieu of the approach currently utilized today related to trauma costs.* Trauma activation fees are charged by trauma center hospitals in other states. These fees provide a mechanism for hospitals to recover costs of maintaining a trauma service by charging trauma patients' public or private insurer. The Commission to Study Trauma Funding recognizes that trauma activation fees can impose a significant additional cost on patients, especially patients that trigger trauma protocols but may not be seriously injured.

   Should HSCRC implement trauma activation fees, consideration should be given to appropriately scale the activation fees to the scope of the trauma team that needs to be activated.

B. Recommendations Pertaining to Changes in Trauma Center Regulations

1) When COMAR 30.08 Designation of Trauma and Specialty Referral Centers is next open for review, the review panel should consider efficiencies that could reduce administrative and clinical costs.

   Rationale: A stakeholder panel specifically convened to consider updates to COMAR 30.08 is the appropriate workgroup to review and update these complex regulations and balance the high standards with costs to trauma center hospitals of complying.

C. Recommendations to the Medicaid Administration

1) Medicaid shall conduct a periodic audit to confirm that Medicaid MCOs are appropriately reimbursing trauma providers at the Medicare rates.

   Rationale: Note that the Medicaid Administration and Medicaid MCOs are not financially responsible for the elevated fee levels (Medicare). The difference between what the Medicaid payer reimburses, and the Medicare payment level is paid by the Fund. MHCC has

concluded that some Medicaid MCOs are not paying the elevated rates on certain trauma services delivered at trauma centers by surgical and nonsurgical specialties.

No Statutory Changes Needed

D. Recommendations To Modify the Existing Scope of the Maryland Trauma Physician Services Fund (Fund)

1) The General Assembly should give Maryland Health Care Commission more discretion in distributing funds.
   a. The cap on trauma equipment grants should be removed.
   b. The MHCC should be permitted to award other operating grants subject to the availability of funds.
   c. The MHCC should be directed to maintain a Fund reserve of no more than 10% of total MVA revenue in a given year and given the ability to disburse these funds above the 10% reserve requirement.
   d. MHCC should be given authority to reimburse non-physician practitioners operating at the trauma center hospital to receive uncompensated care and Medicaid underpay adjustments from the Fund.
2) On-call payments from the Trauma Fund should be expanded to on-average 50% of trauma on-call stipends.
3) Hospitals that pay on-call stipends for non-surgical specialties (Emergency medicine and critical care), other surgical specialties (cardiac, hand; microvascular replant or flaps, obstetric and gynecologic, ophthalmic, maxillofacial, otorhinolaryngologic, pediatric, plastic, thoracic, urologic, and vascular) other non-surgical (cardiology, pulmonary medicine, interventional radiology, interventional angiography, pediatrics, gastroenterology, infectious disease, internal medicine, nephrology, neurology, pathology, physiatry, psychiatry) should be eligible to collect a portion of those costs from the Trauma Fund.
4) Hospitals that pay standby stipends (which are allowable hospital costs) for non-surgical specialties (Emergency medicine and critical care), other surgical specialties (cardiac, hand; microvascular replant or flaps, obstetric and gynecologic, ophthalmic, maxillofacial, otorhinolaryngologic, pediatric, plastic, thoracic, urologic, and vascular) other non-surgical (cardiology, pulmonary medicine, interventional radiology, interventional angiography, pediatrics, gastroenterology, infectious disease, internal medicine, nephrology, neurology, pathology, physiatry, psychiatry) should be eligible to collect a portion of those costs through HSCRC rates.

<u>Rationale 1a-c:</u> Trauma equipment grants are needed to replace equipment dedicated to trauma care. MHCC is permitted to issue grants every other year, but the total funded can be no more than 10% of the balance in the Trauma Fund.

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Rationale 1d: Non-physicians often work alongside trauma physicians in the trauma center. These practitioners should qualify for uncompensated care and Medicaid supplemental payments like physicians.

Rationale 2: On-call payments have expanded rapidly and now constitute over 66% of Trauma Funds obligations, but these payments have not kept pace with the on-call trauma stipends paid by hospitals to trauma surgeons, orthopedists, neurosurgeons, and anesthesiologists. On- call payments are critical to sustaining the Maryland Trauma System.

Rationale 3-4: These specialists are sometimes needed for trauma care. On-call and standby costs are assumed to be considerable smaller than for the required surgical (trauma surgeon, orthopedists, neurosurgeons) and non-surgical specialists (anesthesiologists).

Statutory Change Required for all Recommendations.

E. Recommendations on Trauma Funding

1) Identify additional potential sources of funding for trauma center costs. (automobile moving violations, gun and ammunition sales, marijuana (cannabis) sales.
2) Raise the MVA assessment on vehicle registrations and registration-renewals from $5 per biannual registration to $6 per biannual registration.
3) Allow the General Fund to transfer funds to the Trauma Fund.

Rationale: Current trauma center needs are greater than current revenue. Trauma Fund reserves develop because of the specificity in the current statute. If additional trauma center needs are to be funded, additional revenue will be needed.

Statutory Change Required for all Recommendations.