maryland
health services
cost review commission

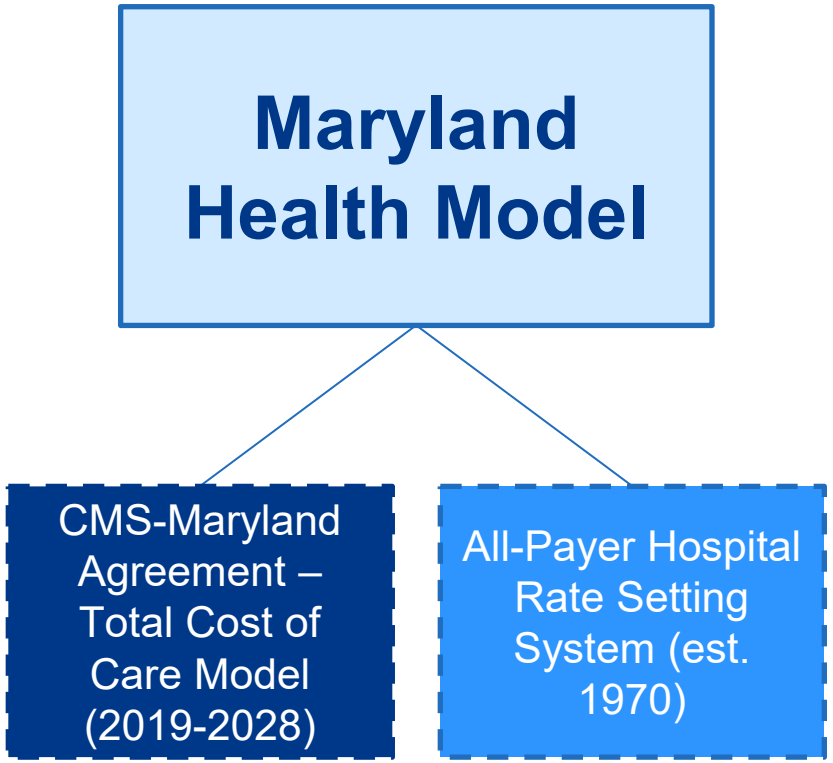
How Trauma Center Costs Are Considered in Hospital Global Budgets

Commission to Study Trauma Center Funding

Presentation from HSCRC Staff

September 29, 2023

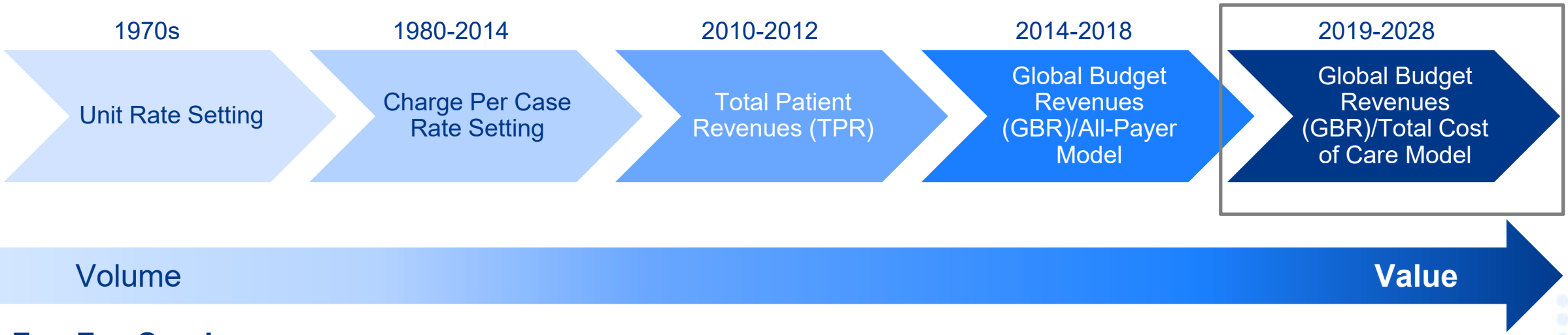
Maryland's Unique Healthcare Payment System



Strengths of the Maryland Health Model:

- Enables **cost containment** for the public
- Ensures all-payer **hospital charges correlate with costs**
- Guarantees **equitable funding of Uncompensated Care**
- Creates **transparency and cost savings** for the public and a **stable financing system** for hospitals
- Funds **investments in population health**
- Establishes Maryland as a **leader in linking quality and payment**
- Provides **support for pioneering state healthcare infrastructure** and subject matter expertise
- Incentivizes **care transformation** across all settings of care
- Invests **in primary care**
- Allows for **innovation**

The Progression of Maryland's System



Fee-For-Service Reimbursement
Revenue = Price * Quantity

Hospitals were incentivized to bring in more patient volume

Per Capita, Value-Based Reimbursement under Global Budget Revenue (GBR)

Hospitals have utilization and quality incentives to focus on keeping people well, reducing avoidable admissions and readmissions

TCOC adds focus on health equity, community and population health, and constrained growth in total costs of care (Part A and B)

Key Components of the Global Budget Revenue (GBR)

Components of the Update Factor

Common GBR Methodology
Fixed revenue based on 2013 Hospital Experience
Adjustments for Inflation Typically around 3% and includes drug costs changes
Population and Volume Adjustments Ensures GBRs reflect hospital patient demographics and population growth as well as growth in innovative care
Adjustments for Quality and PAU Savings Adjusts hospital revenues based on quality outcomes and levels of Potential Avoidable Utilization
Efficiency, Capital, and Rate Adjustments Measures efficiency of care delivery, provides budgetary advances to cover non-variable expenses and investments, and allows for other adjustments to rates
Special Funding Programs Provides funding to hospitals to support statewide goals

Other GBR Components
HSCRC assesses hospital GBR to help pay for CRISP, HSCRC (User Fees), Medicaid Deficit Assessment, and other programs (e.g. Nurse Support Program)

Other Impacts on Hospital Revenue
Medicare Performance Adjustment Includes a Traditional MPA program and the MPA Framework
New Model Programs Includes the Care Transformation Initiatives and Care Redesign Programs (Episode and Hospital Care Improvement Programs)

How are Trauma Costs Covered in the HSCRC Policies?

Item	Pre-GBR	Post-GBR	Direct	Indirect	Description
Casemix Adjustment	X	X		X	The HSCRC adjusts for the severity of cases to recognize their enhanced cost profile, which indirectly benefits trauma facilities in financial methodologies because trauma cases are high severity (e.g. neurosurgery cases had a CMI of 2.4 in CY 2022 vs a statewide average of 1.0 for all cases)
Cost Credits in Efficiency Policies	X	X		X	The HSCRC historically has provided a cost credit in its efficiency policies for the incremental costs required to have regulated standby physician coverage and to comply with MIEMSS regulatory requirements.
Annual Update Factor	X	X	X		The Commission does not rebase hospitals each year based on an efficiency assessment, but rather inflates either prices (Old Model) or revenue (TCOC Model), inclusive of all trauma cases
Full Rate Applications	X	X	X		FRA's allow the Commission to engage in a zero-based budgeting exercise that may increase hospital prices or revenue if all hospital costs are deemed reasonable and charges are not reasonably related to those costs
Price Scaling	X		X		Historically, the Commission has scaled annual inflation based on a hospital's charge per case assessment
GBR Modifications		X	X		In lieu of price scaling, the Commission now relatively ranks hospitals based on charge per case AND TCOC performance and provides additional funding to the most efficient and effective hospitals
Volume Increases	X		X	X	Increases in cases were previously funded through a fee-for-service reimbursement system that could directly benefit trauma facilities for growth in trauma cases or could indirectly benefit trauma facilities if growth in non-trauma cases was reimbursed above marginal costs
Marketshifts & Demographic Adjustments		X	X	X	Funding is provided for population growth and for shifts in the market, which may be directly due to trauma cases or indirectly by non-trauma volumes. Additionally, potentially preventable utilization, e.g., readmissions, that is avoided improves the hospitals bottom line because the associated funding is not removed.

- Prior to global budgets, price setting allowed the Commission to fund trauma coverage both directly and indirectly
- The global budgets established in 2014 were based off of hospital revenues from 2013, i.e. baseline costs were covered
- Post-GBR, various policies continue to fund trauma coverage both directly and indirectly
- HSCRC policies purposefully do not fund all trauma costs, i.e., unregulated physician subsidies, as that is beyond the Commission's regulatory authority

Full Rate Reviews

Purpose

- Allows staff to review the entire regulated structure at a hospital. The process ensures the HSCRC is abiding by its legal mandate that:
  - Total costs of hospital services offered by or through a facility are reasonable
  - The aggregate rates are related reasonably to the aggregate costs of a facility
  - Rates are set equitably among all purchasers or classes of purchasers of health care facility services without undue discrimination or preference.
- The full process is outlined in Md. Code, Health-Gen. §19-222 and COMAR 10.37.10.03 et seq

How it Works

- Full rate applications can be initiated by the Hospital or the HSCRC
- During review of the rate application, HSCRC staff utilize:
  - The Inter-Hospital Cost Comparison (ICC) to compare hospital cost per case efficiency
  - TCOC measures with geographic attribution to evaluate per capita cost performance, both for Medicare and Commercial
- Any additional analysis that HSCRC staff deem appropriate including:
  - Financial condition of hospital;
  - Volume growth or decline, especially in Potentially Avoidable Utilization; and
  - Quality performance

Hospital Reporting

Data Source	Annual Cost Report
Description	Report of detailed cost, volume, revenue, and staffing data by hospital department
Primary Use	Rate setting, productivity reports, and to align approved rates to ensure rates are related to costs during the reported fiscal year.

Schedule MTC – Incremental MIEMSS Requirements for Trauma Hospitals

- This schedule enables hospitals with designated trauma centers to report the incremental trauma costs incurred to meet the Maryland Institute for Emergency Medical Service Systems regulatory requirements. Such incremental costs are the costs associated with operating a hospital with a designated trauma center that are over and above the costs normally associated with hospitals that do not have a designated trauma center. These incremental costs include:
  - Trauma Director
  - Trauma Department
  - Trauma Protocol
  - Specialized Trauma Staff
  - Education and Training
  - Special Equipment
- The cost credit in HSCRC efficiency policies is based on the cost that was reported in 2003, which is then inflated forward based on the inflation provided in the Annual Update Factor.

Schedule SBC I & II – Standby Costs Trauma Physicians

- These schedules enables hospitals with designated trauma centers to report standby costs of trauma physicians.
  - Trauma Surgeons
  - Orthopedic Surgeons
  - Neurosurgeons
  - Anesthesiologists
- These costs are defined as the cost generated as a result of the necessity to have the physical presence of a trauma physician under a formal arrangement to render services to trauma patients. These physicians must be on the hospital premise in reasonable proximity to the ED or trauma department. They may not be “on-call”.
- The cost credit in HSCRC efficiency policies is based on the cost that was reported in 2003, which is then inflated forward based on the inflation provided in the Annual Update Factor.

Conclusion

- Our statute does not allow us to regulate physicians
  - We do account for MIEMSS/standby costs, but we can not per legislation, regulate physician fees
- We must be careful and thoughtful about what we fund in rates because
  - we are required to have charges reasonably related to cost, per statute, and;
  - to maintain All-Payer rate setting we must our TCOC Model tests