Maryland Institute for Emergency Medical Services Systems

Maryland Health Care Commission

Agenda and Overview of the Trauma Physician Services Fund

Maryland Commission on Trauma Funding

August 10, 2023

Commission on Trauma Funding
August 10, 2023 Agenda

1) Welcome and Introductions

A) Through what lens do you have perspective regarding trauma center funding?

B) What is your overall assessment of the challenges and opportunities in Maryland?

2) Statement of Purpose and Charge of the Commission

3) History of the Maryland Trauma Physicians Service Fund

- General background of the Fund
- What it funds and what it does not fund
- Trauma Fund Formula

4) Next Steps

Schedule second meeting date

Topic Meeting #2: Challenges of Trauma Centers and current payment streams

Introductions and Perspectives

Describe your role in delivering trauma care or financing of trauma care at your organization;

- 1) Through what lens do you have perspective regarding trauma center funding?

- 2) What's your overall assessment of the challenges and opportunities facing trauma care in Maryland?

Please limit comments to 5 minutes

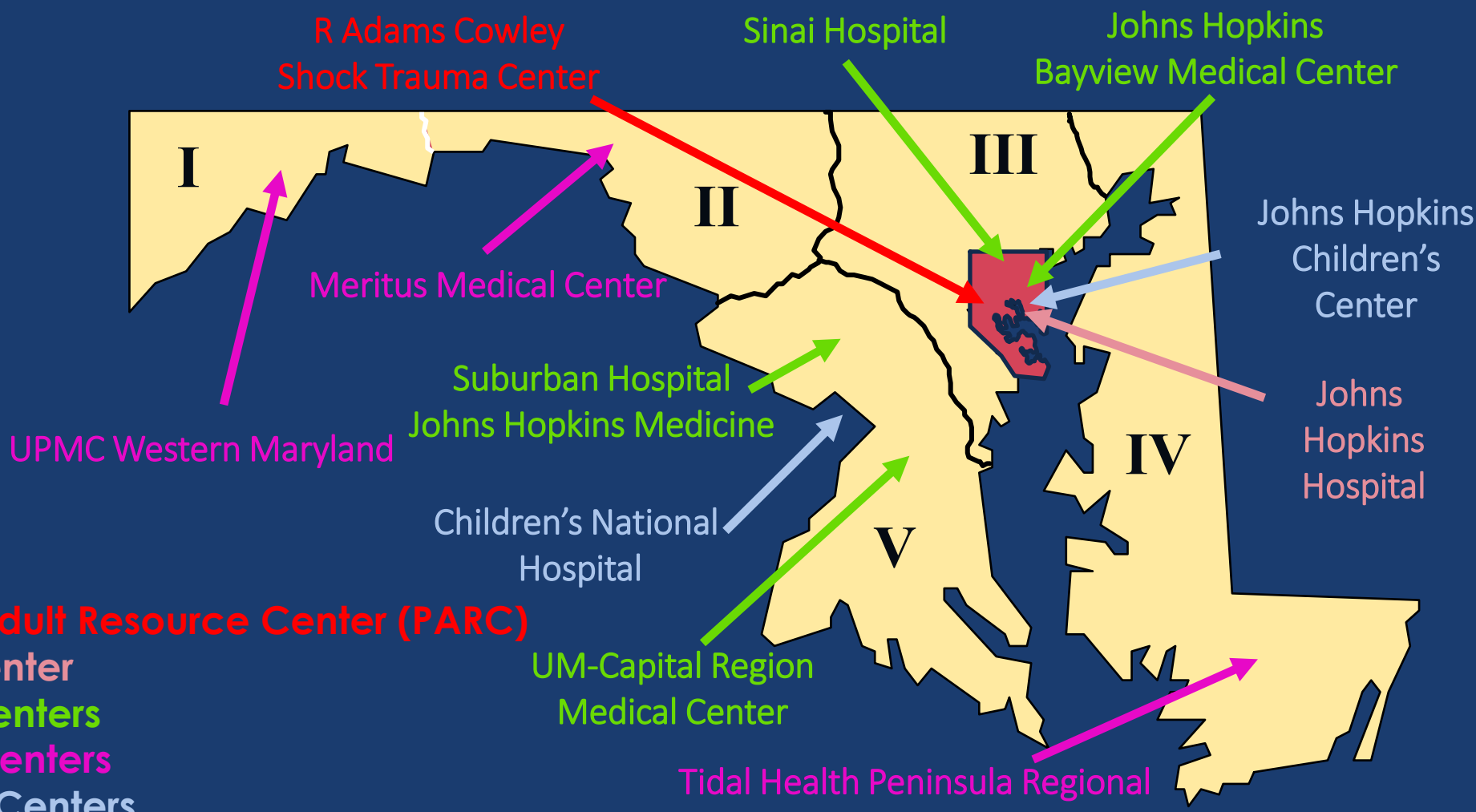
A Word About Maryland's Nationally Recognized Trauma System

	Trauma Level	2005-2006	2019-2020	2020-2021	2021-2022
Johns Hopkins Bayview Medical Center	II	1,497	4,044	3,816	2,634
Johns Hopkins Medical System	II	1,900	1,603	1,717	2,206
Meritus Medical Center	III	938	1,979	2,426	2,761
R Adams Cowley Shock Trauma Center	PARC	6,119	5,843	5,958	5,154
Sinai Hospital of Baltimore	II	1,748	2,016	2,273	2,565
Suburban Hospital – Johns Hopkins Medicine	II	1,433	1,256	1,957	2,007
TidalHealth Peninsula Regional	III	1,168	1,160	1,662	1,661
UM Capital Region Medical Center	II	3,075	3,096	3,021	2,872
UPMC Western Maryland	III	668	525	506	638
The Johns Hopkins Pediatric	PEDs	995	750	760	894
TOTAL		19,541	22,272	24,096	23,392
Source: MIEMSS Annual Reports					

CY 2022: 24,485

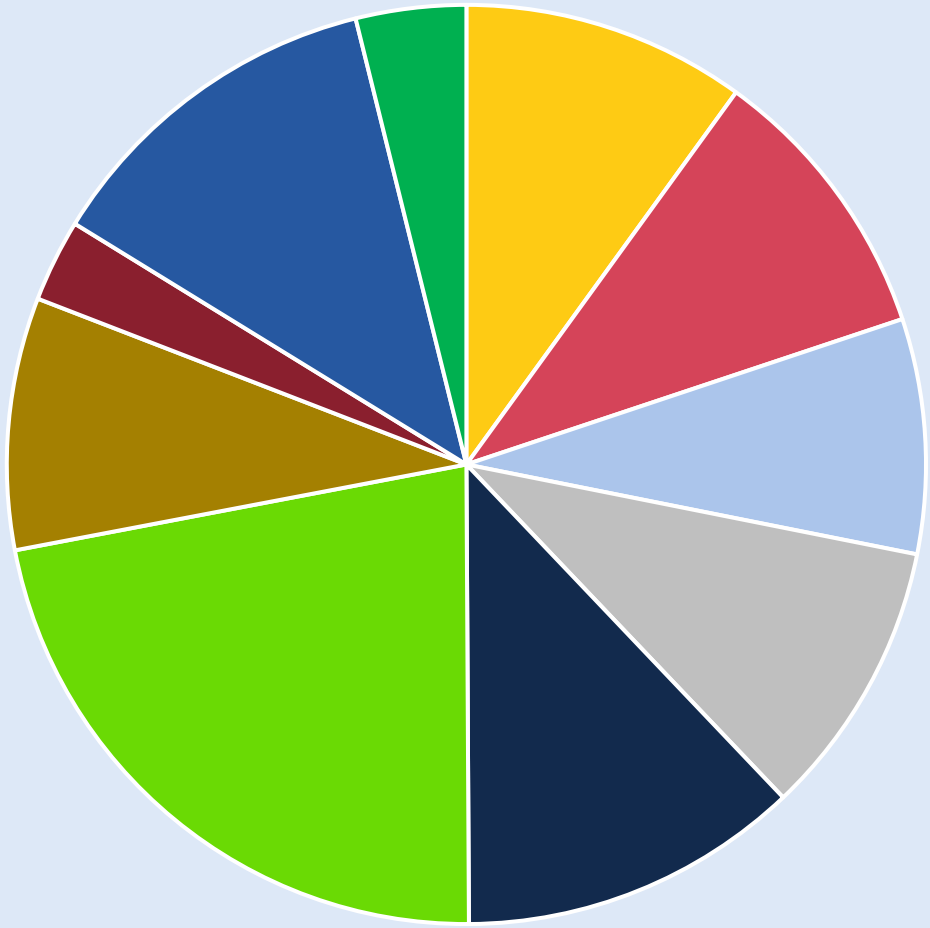
Maryland Trauma Centers

PARC, Adult Level I – III, and Pediatric

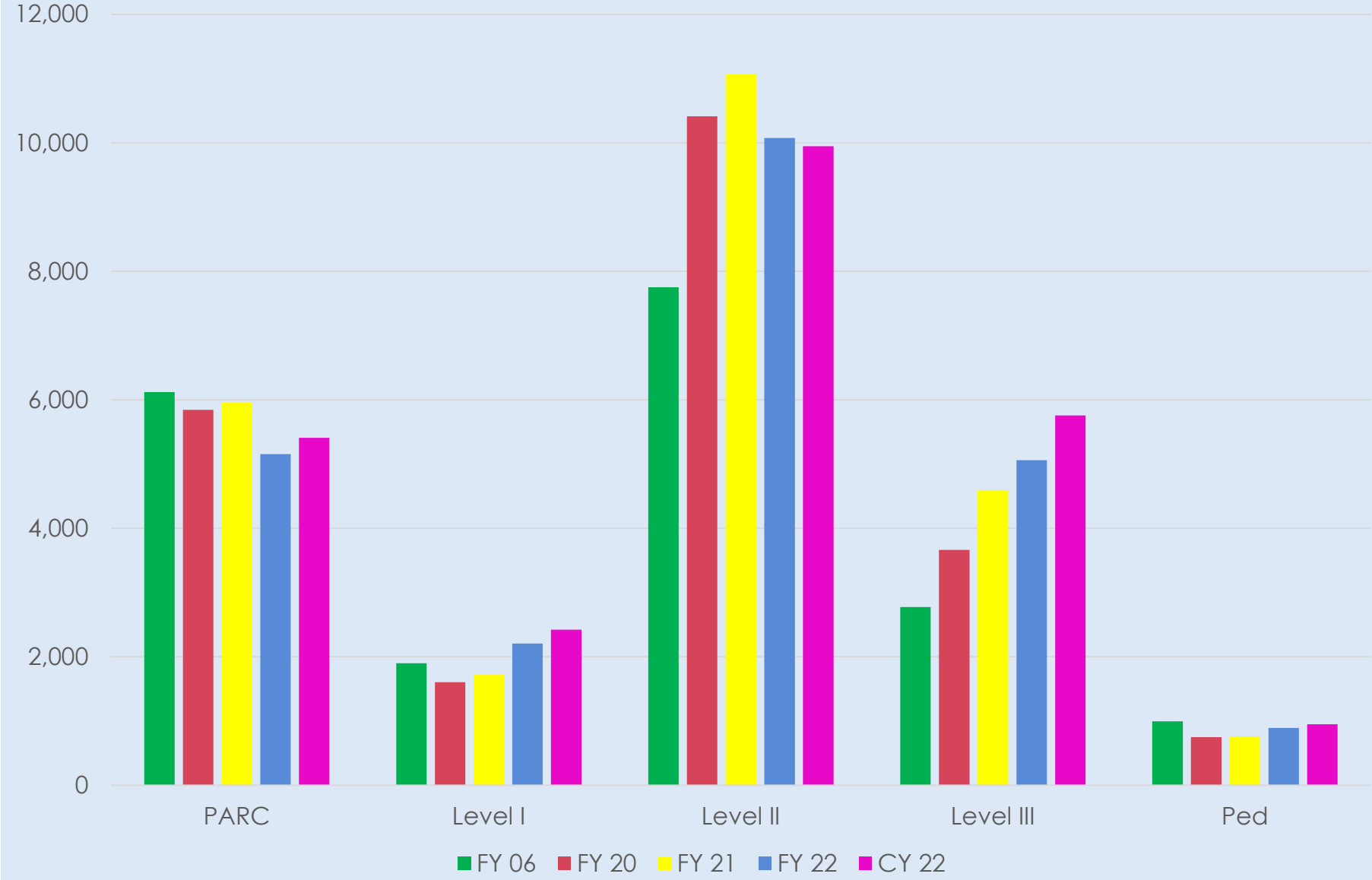


1 Primary Adult Resource Center (PARC)
1 Level I Center
4 Level II Centers
3 Level III Centers
2 Pediatric Centers

Trauma Patient Distribution (2022)



Trauma Patient Volume per Year

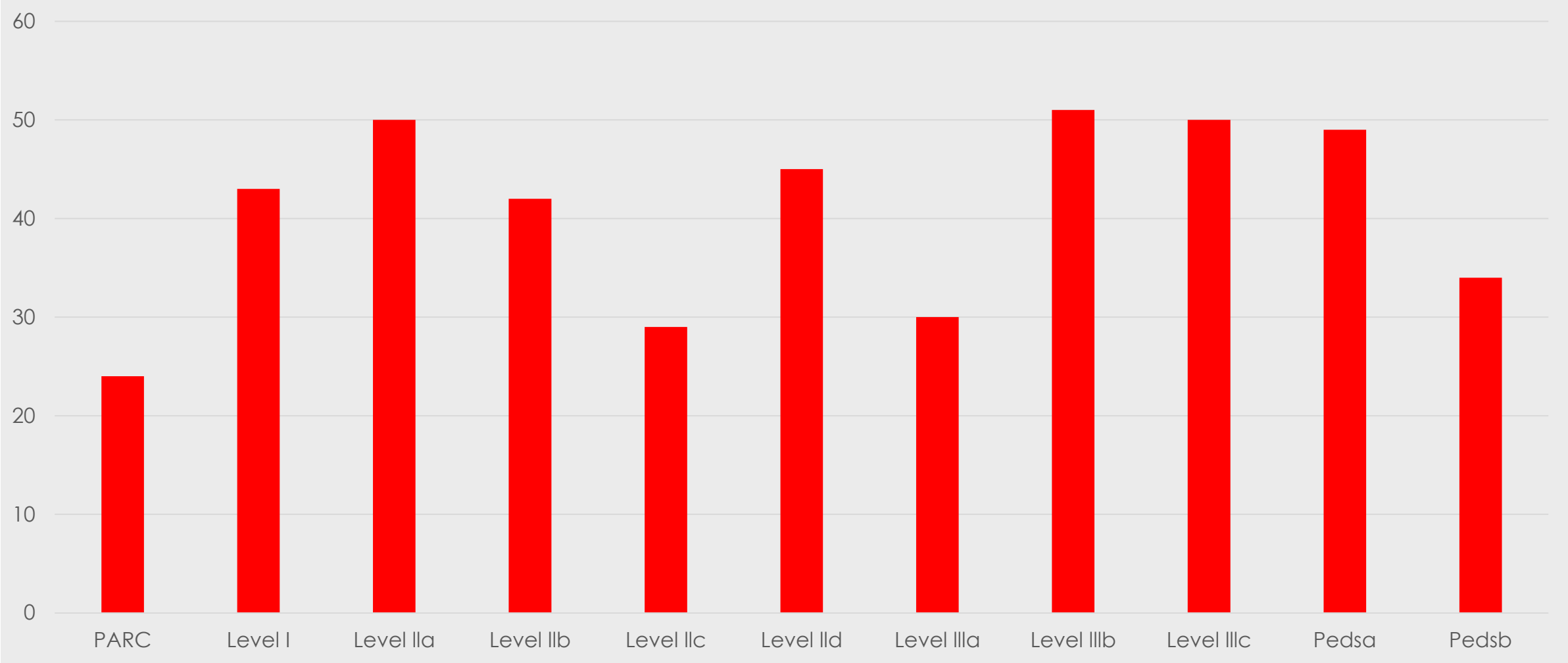


Comparing Injury Severity

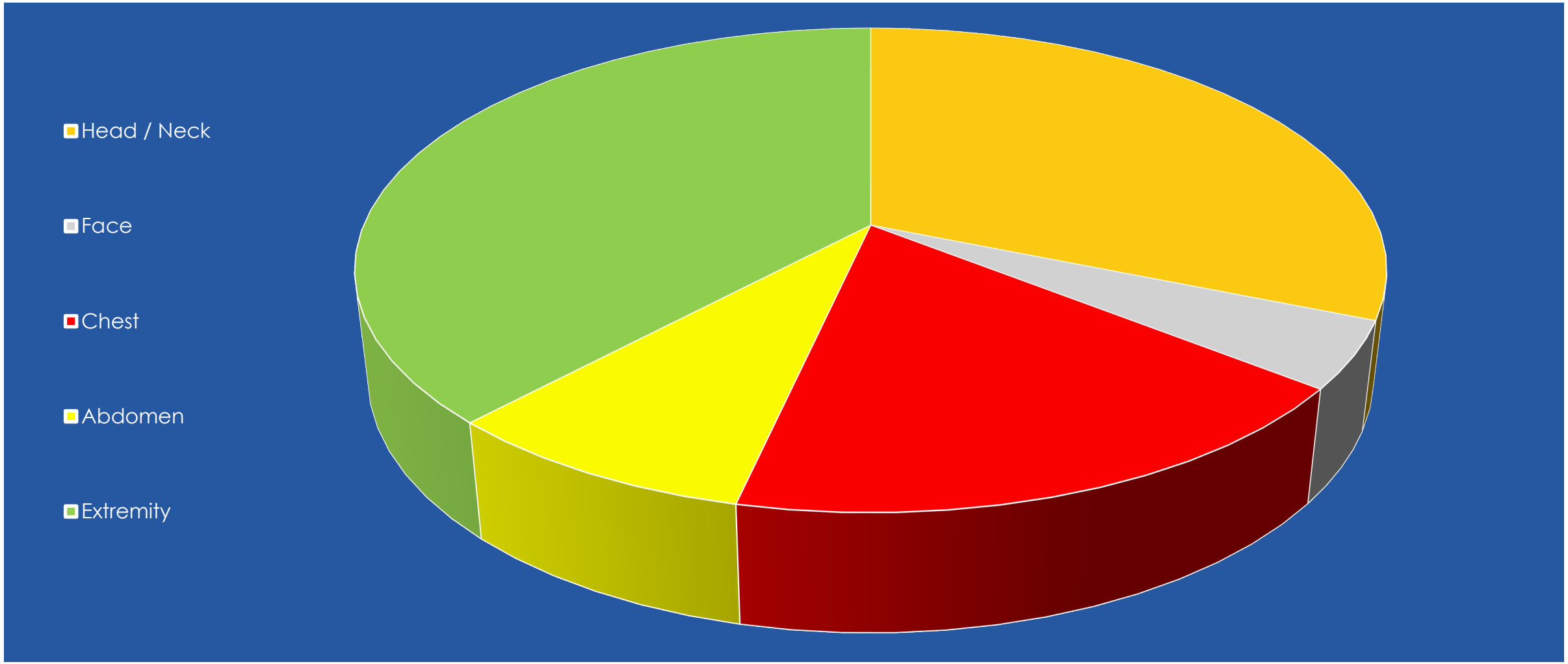
- Abbreviated Injury Scale (AIS)
  - Anatomically-based severity scoring system
  - 9 body regions
  - Each injured region scored 1 (minor) to 6 (maximal; untreatable)

- Injury Severity Score (ISS)
  - The sum of the squares of the three highest AIS regions ($ISS = A^2 + B^2 + C^2$)
  - < 3 indicates minor or no injury (3 or fewer injured regions with minor injuries)
  - > 15 indicates severe injury

% Minor or No Injury



Anatomic Region "Most Injured"



History of the Trauma Physician Services Fund

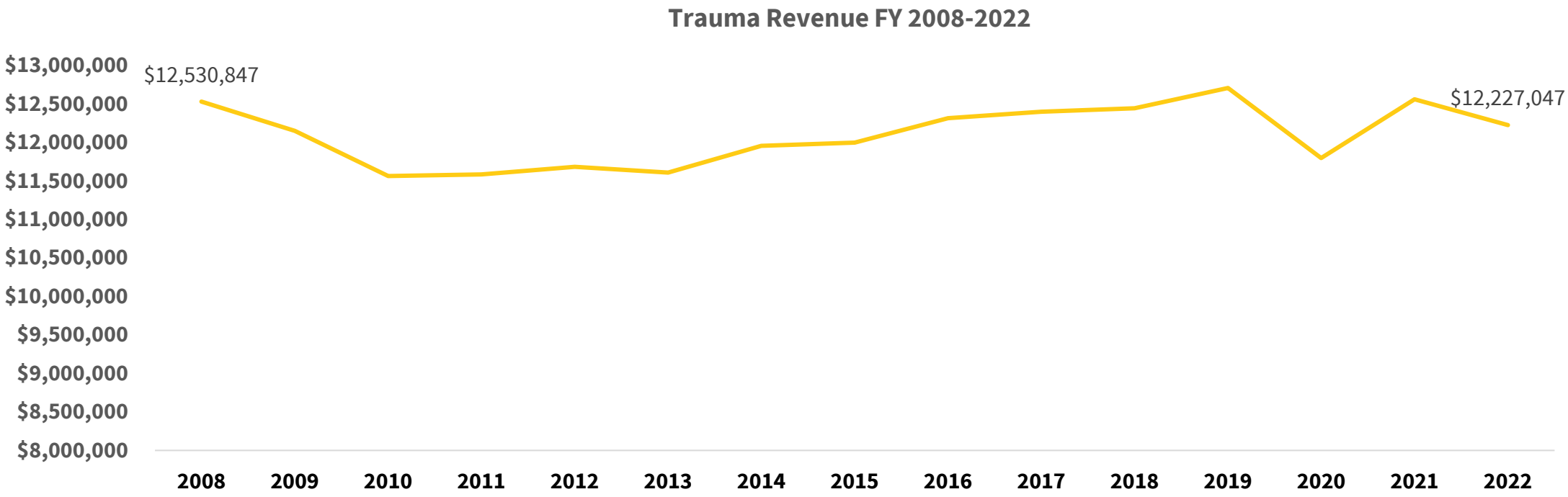
- Established after Washington County Hospital (now known as Meritus) closed its Level II Trauma Center in 2002
- Legislature established Maryland Trauma Physician Services Fund in 2003 legislative session and funded it through automobile registration fees ($5 bi-annually)
- Covered care delivered at the nine Maryland adult trauma centers and two pediatric centers (Johns Hopkins and Children National Medical Center). JHU Bayview Burn Center, JHU Wilmer Eye, and Curtis Hand at Medstar became eligible several years later.
- Four funding streams:
    1) on-call and standby paid to hospitals for documented availability costs,
    2) Medicaid supplemental payments paid to practices,
    3) uncompensated care paid to practices, and
    4) Standby stipends included HSCRC-approved rates.
- After the initial legislation was passed, Washington County Hospital Trauma Center reopened as a Level III center

<u>Note:</u> on-call payments are paid to physicians that are required to respond in 30 minutes. Standby payments are paid to physicians already at the hospital and ready to respond. On-call and standby together are sometimes referred to as availability payments.

Limitations in the Statute

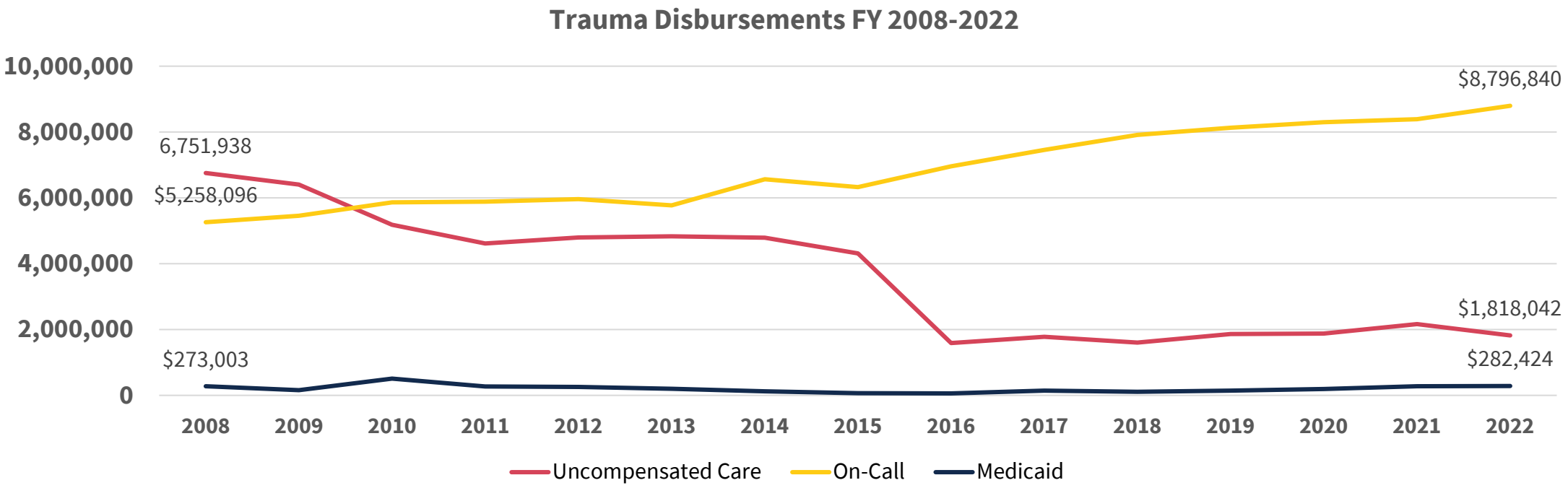
- Legislation was a balancing ‘act’, the major funding streams were specifically defined in statute.
- MHCC and HSCRC, the administrators of the fund, have limited flexibility to balance funding based on available trauma needs and reserve levels.
  - Can award trauma equipment grants but limited to 10% of the Fund balance.
  - On-call formula is defined in the statute
  - Trauma centers can increase standby payments included in their hospital rate only via a full rate review
- Lack of flexibility -- certain trauma expenses not reimbursed, yet fund balances have developed because of inflexible standards.
- But…MHCC can decrease/increase fee levels for uncompensated care payments above 100% of the Medicare Fee Schedule.

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

On-call and Standby Payments

- Original statute provided for on-call and standby payments to Level II and III trauma centers.
- On-call and standby payments are paid to trauma centers for the costs of trauma surgeon, orthopedic surgeon, neurosurgeon, and anesthesiology on-call and standby.
- On-call and standby formula were designed to pay a portion of trauma center costs for on-call and standby.
- JHU Level I and PARC became eligible for standby payments in recent years.
- On-call and standby formulae were pegged to the CMS reasonable compensation equivalent. Reasonable compensation equivalents are no longer used by CMS.
  - On-call formula is updated by the MEI for the physician compensation component of the Medicare Fee Schedule.
  - Standby formula is updated HSCRC annual update factor.
  - On-call now constitutes about 75% of trauma fund reimbursement.

Thoughts About On-Call and Standby

- Since the early 2000s, the market trends indicate that physicians have been less willing to provide ‘availability; services without additional financial support from the hospitals.
- Availability and activation costs are major contributors to the costs of serving as a Level II or Level III trauma centers.
- Use of CMS Reasonable Cost Equivalents reflected preference for covering some on-call and standby costs. Legislative intent was that hospitals should be accountable for controlling on-call and standby stipends. stipends.
- Sullivan Cotter and Associates, Medical Group Management Association, and Buckhead FMV, LLC publish physician and APN compensation studies based on surveys. These studies provide estimates of ‘availability’ payments, which typically include on-call and standby coverage services.

Uncompensated Care and Medicaid Payments

- 2003 statute allowed trauma surgeons, orthopedic surgeons, neurosurgeons, anesthesiology, critical care, and emergency medicine to bill the Trauma Fund for uncompensated care. These specialists received 100% of the MFS for services provided to trauma patients insured by Medicaid or lacking health insurance.
- Key changes …
  - 2006 - All physicians providing services directly related to the trauma injury are permitted to bill the Fund.
  - 2008 - Sites of service expanded to include the initial trauma admission: emergency visits, initial hospitalization, follow-up inpatient stays at the trauma center, claims for care provided at a trauma-center-affiliated rehabilitation hospitals, and outpatient visits at the trauma center.
- Non-physicians are not permitted to bill the Fund
- Uncompensated care payments have declined since 2014 as the ACA expanded coverage to Medicaid and commercial insurance.
- MHCC has not seen a parallel increase in Medicaid trauma payments. Medicaid reimbursement levels are close to Medicare. Questions remain on whether MCOs pay 100% of Medicare payments on trauma claims.

Recent Payments for Uncompensated Care CY 2018-2022

	Uncompensated Care Patients					Uncompensated Care Trauma Payments Per Capita				
Race/Ethnicity	2018	2019	2020	2021	2022	2018	2019	2020	2021	2022
Hispanic	459	483	387	331	288	$1,258	$862	$1,389	$1,727	$1,387
Asian, NH	18	16	11	10	10	$1,812	$819	$2,239	$1,126	$1,256
Black, NH	647	712	653	441	253	$1,032	$824	$997	$943	$1,443
Other race / multiple races, NH	89	94	103	51	38	$1,020	$971	$1,645	$707	$2,314
White, NH	343	359	271	301	168	$1,007	$957	$1,394	$855	$1,862
All Patients	1,556	1,664	1,425	1,134	757	$1,102	$872	$1,235	$1,139	$1,556

Post ACA 5-7% of trauma patients qualify for uncompensated care. Uncompensated care volumes could increase as Medicaid re-determinations continue. Uncompensated care payments per capita are on average modest, payments for some trauma cases are relatively small because trauma protocols are activated but the cases are resolved in the ED.

Since implementation of ACA coverage expansions, higher percentages of patients eligible for uncompensated are probably non-citizens not eligible for Medicaid or commercial insurance through the Health Insurance Exchange.
CY 2022 covers January-July 2022 .

Source: MHCC analysis of Uncompensated Claims 2018-2022

A Recent Comparison: Revenue Collected and Obligations Paid in FY 2022 Compared to FY 2021

- Revenue collected in FY 2022 was $12.2 million compared to $12.5 in FY 2021. In FY 2020, revenue was $11.8 million.
  - Most significant revenue decline was in FY 2020.
- Uncompensated care costs totaled $1.8 million compared to $2.1 million in FY 2021.
  - Uncompensated care driven by numbers of uninsured treated for trauma injuries
- Medicaid payments totaled $ .280 million compared to $ .275 million in FY 2021
- Payment for On-Call Services totaled $8.8 million compared to $8.4 in FY 2021.
  - Almost all trauma hospitals are now collecting the maximum on-call allowed by law. Increases are mostly driven by automatic inflation increases in the maximums.

Modifying Trauma Fund Revenues and Expenditures
Past MHCC Recommendations

Overarching requirement is to allow flexibility in use of the MVA revenue to address evolving trauma centers needs.

1. Increase MVA surcharge on registration and registration renewals from $5 to $6.
2. Increase Medicaid supplemental payments at 105% of Medicaid or higher.
3. Increase level of trauma equipment grants to $1 million per year for eligible trauma centers and remove funding cap on the existing Trauma Fund reserve.
4. Authorize UCC and Medicaid supplemental payments for non-physician practitioners providing trauma care.
5. Replace Reasonable Compensation Equivalents or increase the % of RCE payable as on-call.
6. Expand eligibility for on-call and standby to other specialties activated to provide trauma care.
7. Allow trauma centers to recover nursing costs associated with trauma
8. Direct MHCC to conduct annual reviews of UCC and Medicaid supplemental payments to confirm Managed Care Organizations are reimbursing at mandated levels. Payments above their MCO negotiated rates are chargeable to the Trauma Fund.
9. Eliminate the multiple procedure reductions for Medicaid trauma services

Changes 1-7 would require a change in the statute and No. 9 may require a Medicaid State Plan Amendment

Next Steps

Meeting 2 - Mid-September:

- Trauma Center Experience in the US and Maryland: Parallels and Differences
- Impact of the Maryland Model on Trauma Care Services and Reimbursement
- Unmet Trauma Care Needs in Maryland