MARYLAND TRAUMA PHYSICIAN SERVICES FUND

Health General Article § 19-130

Operations from July 1, 2004 through June 30, 2005

To The

MARYLAND GENERAL ASSEMBLY

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Summary

The purpose of the Maryland Trauma Physician Services Fund (Fund) is to stabilize the trauma system in Maryland by reimbursing trauma physicians for costs associated with treating trauma patients. This annual report on the Fund for fiscal year 2005 meets the reporting requirement under the Health General § 19-130(e) that directs the Maryland Health Care Commission and the Health Services Cost Review Commission to report to the Maryland General Assembly on the status of the Fund.

The Fund covers the costs of care provided to uncompensated care and Medicaid enrolled patients as well as the trauma related on-call expenses for trauma physicians that provide treatment at Maryland Institute for Emergency Medical Services Systems (MIEMSS) designated trauma centers. The Fund is financed through a $5 surcharge on motor vehicle registrations and renewals. During FY 2005, the MVA collected approximately $11.7 million and the Maryland Health Care Commission (MHCC) approved outlays of about $4.5 million from the Fund. At the end of FY 2005, the Fund was $15.4 million. The Fund also has $2.9 million in on-call and uncompensated care obligations for FY 2005 services submitted in July 2005.

The level of Medicaid reimbursement under the Fund has not met expectations. During the legislative debate, MHCC and HSCRC estimated that the State's share of elevated Medicaid payments would total $2 million annually. Actual disbursements have been much smaller, as payments for services provided under traditional Medicaid totaled about $250,000 through May 2005. Medicaid MCOs experienced some difficulty implementing changes required in their claim adjudication systems, but all were making payments at the higher rates by January 2005. The Fund will reimburse Medicaid for about $90,000 in MCO payments through the first half of 2005 in September of 2005. Future Medicaid payments under the Fund will be smaller because Medicaid fees will increase to 100 percent of Medicare for orthopedic, neurosurgery, and some emergency medicine services.

The report describes options for expanding eligibility for participation in the Fund. Some minor expansions are possible via regulatory changes, but broader expansions require legislative action. Given the sizeable balance in the Fund, the General Assembly may wish to expand eligibility to the Fund. The report briefly outlines possible options which, if implemented, could increase Fund disbursements by $4.8 million in FY 2007. MHCC and HSCRC are ready to provide additional information on the costs of these options.

Background

During the 2003 Legislative Session, the Maryland General Assembly adopted the Maryland Trauma Physician Services Fund to aid Maryland's trauma system by reimbursing trauma physicians[1] for uncompensated care losses and by raising Medicaid payments to 100 percent of the Medicare rate when a Medicaid patient receives trauma care at a designated center. The legislation also established a formula for reimbursing trauma centers for trauma-related on-call expenses for trauma surgeons, orthopedists, neurosurgeons, and anesthesiologists.[2] The legislation directed the HSCRC to ensure hospitals are able to include trauma-related standby expenses in HSCRC-approved hospital rates. Governor Robert L. Ehrlich, Jr. signed the legislation on May 22, 2003 as Chapter 33 of 2003 Laws of Maryland.

Application, Payment, and Audit Processes

Trauma physicians and trauma centers can seek reimbursement for uncompensated care services and on-call costs from the Fund on a semi-annual basis. Physicians and trauma centers can submit uncompensated care and on-call applications in January and July of each year. Medicaid providers can submit trauma claims to Medicaid on an ongoing basis to receive up to 100 percent of the Medicare Baltimore locality rate. Administrative operations of the Fund are handled by MHCC staff. Applications for uncompensated care and on-call costs are reviewed by MHCC staff for completeness and accuracy. Uncompensated trauma care services were reimbursed at 100 percent of the 2004 Medicare rate for that service in the Baltimore area pricing locality. On-call expenses in calendar year 2004 were reimbursed for the number of on-call hours provided. MHCC's existing contract with Clifton Gunderson ran from March 2004 through June 2005. MHCC extended the term of its contract with Clifton Gunderson from June 30, 2005 to September 30, 2005.[3]

[1] COMAR 10.25.10 defines trauma physicians as trauma surgeons, anesthesiologists, orthopedic surgeons, neurosurgeons, critical care physicians, and emergency room physicians.

[2] On-call requirements under the Maryland Institute for Emergency Medical Services Systems (MIEMSS) standards for Maryland trauma centers require that physicians be available to respond within 30 minutes. Standby requirements state that the physician must be at the facility ready to respond. Level III trauma centers operate with all trauma physicians on-call status, although a center is permitted to have physicians on standby. Level II centers must have trauma surgeons on standby status, but other physicians are permitted to be on call. Level I centers must have physicians in all MIEMSS-designated specialties on-site at all times.

[3] MHCC notified Clifton Gunderson, LLP, that it has invoked a "no cost contract extension" for the Fund Audit contract that will extend the period of service until September 30, 2005.

MHCC contracts with Clifton Gunderson, LLP, to review the on-call, standby, and uncompensated care applications submitted to the Fund. Clifton Gunderson, LLP, completed reviews for services provided during the 6-month reporting cycle that ran from October 1, 2003 through March 31, 2004 and the 3-month reporting cycle from April 1, 2004 through June 30, 2004. In 2004, Clifton Gunderson identified a total of $398,195.42 due from physician practices and trauma centers to the Fund.[4] The auditor billed the Fund for $73,166.50 in expenses for FY 2005.

In April 2005, MHCC requested that Clifton Gunderson, LLP, complete a process review on the Fund's internal operations. Clifton Gunderson was asked to evaluate and recommend enhancements to the processes MHCC put in place. Clifton Gunderson recommended some improvements regarding segregation of work functions. Staff implemented changes that were feasible given budgetary constraints.

Outreach Efforts

MHCC continues to educate physician practices and trauma centers regarding the Fund. These efforts included scheduling on-site educational programs in Cheverly, Hagerstown, and Salisbury, Maryland. MHCC continued to update its Internet Web site with information about the Fund. (The address for this website is www.mhcc.state.md.us/trauma_fund/_trauma.htm.) Items included on the Web site are: on-call and uncompensated care applications, Fund statute and regulations, Physician Information Bulletins issued by MHCC, current on-call payment threshold tables for trauma centers, and the uncompensated care payment schedule. During FY2005, staff issued seven new Physician Information Bulletins (PIBs) that provided instruction and clarification on how the Fund will administer and reimburse on-call and uncompensated care services. A total of twelve PIBs can be viewed on the MHCC Web site.

Status of the Fund

For FY 2005, the Motor Vehicle Administration (MVA) collected approximately $11.7 million dollars in revenue for the Fund. MVA collections increased by about 12 percent from 2004 to 2005, however most of the percent increase resulted from a staggered implementation process. MVA began collecting the $5 fee on automobile purchases in July of 2003, but the $5 fee was not applied to registration

[4] Clifton Gunderson's review of the uncompensated care and on call applications reported a total of $284,752.31 in monies owed in Period 1 2004 and a total of $113,443.11 for Period 2 2004 to the Fund.

renewals until September 2003. A comparison of collections during the last 10 months of each year shows an increase of about 1.8 percent. The month-by-month collection stream is shown in Appendix Table 1.

The balance in the Fund at the end of FY 2005 is $15.5 million. Table 1 summarizes the revenue collected and disbursed during FY 2005 for the services provided from April 2004 through December 2004. During FY 2005, the Fund disbursed $1.7 million in uncompensated care and $2.3 million for trauma expenses incurred through December 2004. Smaller amounts were disbursed to the Medical Assistance Administration, the Children's National Medical Center, and to the Fund's auditor. A discussion of each disbursement category is provided in the following sections.

Table 1 - Trauma Fund Status From Inception (July 2003)

CATEGORY	AMOUNT
Revenue from the $5 Registration Renewal Fee thru 06/30/2005	$ 22,097,012.21
Outlays	
Outlays in Prior Year	$ 2,082,929.84
Outlays for FY 2005—	
-- Uncompensated Care Service for period 4/1/04 - 12/31/04	1,682,973.42
-- On Call Expense for period 4/1/04 – 12/31/04	2,300,338.12
-- Medicaid for Period through 3/31/05	230,966.92
-- Children's National Medical Center Grant for Standby Expenses	206,250.00
-- Audit Expense (Cumulative from Inception through July 12, 2005)	110,000.50
Total Outlays for FY 2005	$ 4,530,528.96
TRAUMA FUND BALANCE END June 2005	$ 15,483,553.41

Outstanding Obligations for FY 2005

The Fund holds outstanding obligations from trauma centers and practices that are not reflected in the year end balance. These obligations are based on provider applications submitted July 31, 2005 for the period from January 1, 2005 through June 30, 2005. The MHCC presents this information to provide a full picture of collections and disbursements during the first 2 years of Fund operations. A reconciliation of the obligations against the Fund balance is shown in Table 2.

Table 2 – FY 2005 Obligations Incurred after Year End

TRAUMA FUND BALANCE END June 2005	$ 15,483,553.41
Uncompensated Care and On-call Amount Incurred but not Paid by June 30, 2005	2,890,868.35
Medicaid & MCO Costs Incurred but not Paid	186,496.26
TOTAL LESS INCURRED COSTS	$ 12,406,188.80

Payment to Practices for Uncompensated Trauma Care

The Fund reimburses trauma physicians at 100 percent of the Medicare rate for uncompensated care services. Before a practice can apply for uncompensated care, they must apply the practices' routine collection polices by confirming that the patient has no health insurance and by billing the patient before the service can be written off as uncollectible and hence eligible for uncompensated care. This requirement is consistent with the legislative intent which made the Fund the payer of last resort for practices providing trauma services. As indicated above, during FY 2005, MHCC authorized $1.7 million in uncompensated care payments to trauma physicians for services provided from April 1, 2004 through December 2004. Physicians affiliated with Johns Hopkins University trauma centers (Hopkins, Bayview, and Hopkins Children) received about 32 percent of total uncompensated care payments, and physicians at Shock Trauma received about 24 percent of total uncompensated care payments. The list of physician practices that received uncompensated care trauma payments for FY 2005 services is shown in Appendix Table 3.

Table 3 -- Trauma Fund Payments

To Trauma Physicians by Trauma Centers

Facility		% of $
R. Adams Cowley Shock Trauma Center	$ 406,978.96	24.2%
Johns Hopkins Adult Trauma Center	$ 366,016.60	21.7%
Prince George's Hospital Center	$ 347,978.35	20.7%
Suburban Hospital	$ 149,955.73	8.9%
Sinai Hospital	$ 112,600.28	6.7%
Johns Hopkins Bayview Medical Center	$ 95,885.50	5.7%
Johns Hopkins Pediatric Trauma Center	$ 80,651.00	4.8%
Peninsula Regional Medical Center	$ 79,224.89	4.7%
Washington County Hospital	$ 35,737.16	2.1%
Western Maryland Health System – Memorial	$ 7,944.96	0.5%
Total	$1,682,973.42	100.0%

Payment for Trauma On-Call Service

The Fund reimbursed trauma centers for the costs of paying trauma physicians to take trauma calls. Table 4 shows on-call payments to trauma centers in FY 2005 totaled approximately $2.3 million. All Level II and Level III trauma centers collected on-call payments in FY 2005, but no facility collected the maximum amount under the Fund's on-call disbursement formula. Among the Level II centers, payments were lowest at Suburban Hospital and highest at Sinai. Peninsula Regional and Washington County hospitals each collected in excess of $500,000 in on-call payments in 2005, but payments were still considerably less than the funds available for the 9 month period covered by this report. Payments were below the available maximum for three reasons: (1) some centers did not pay on-call for all eligible specialties; (2) some centers paid on-call for fewer than the maximum allowable hours (a trauma center collects the maximum if it pays on-call to all eligible specialties for 24 hours a day, seven days a week); and (3) some centers made on-call payments but could not document the amount attributable to trauma calls. In the most recent applications, MHCC found that trauma centers have improved tracking of trauma on-call costs. Those improvements are expected to continue. Appendix Table 3 provides the maximum payment thresholds by specialty for Level II and III trauma centers for the 9 month disbursement period covered by this report.

Table 4 -- Trauma Fund On-Call Payments

To Level II and Level III Trauma Centers

Trauma Facility	Total Paid	Total Available
Level II		
Johns Hopkins Bayview Medical Center*	$ 202,320	$ 394,200
Suburban Hospital	109,200	394,200
Prince George's Hospital Center	264,120	394,200
Sinai Hospital of Baltimore	258,164	394,200
Level III		
Peninsula Regional Medical Center	561,262	678,668
Washington County Hospital Association	584,245	770,017
Western Maryland Health System	321,026	678,668
TOTAL	$ 2,300,338	$ 3,704,153

The on-call payments are based on on-call costs reported by the trauma centers for the period from April 2004 through December 2004. The total available funds are based on maximums available for the 9 month period.

Payment for Services Provided to Medicaid Enrolled Patients

The Medicaid program reported paying approximately $462,000 in enhanced payments under the Trauma Program for the months January 2004 through February 2005. The Federal government and the Fund are each responsible for 50 percent of the difference between the Medicare and Medicaid rates. The Fund's share of payments was about $231,000. Table 5 provides a breakdown of disbursements to the Medicaid program for services provided from January 1, 2004 through February 28, 2005.

Table 5 – Trauma Fund Payments to Medicaid

Service Period	Amount Billed
January -- March 2004	$ 6,411.86
April – June 2004	$ 23,583.60
July – September 2004	$ 61,799.87
October – December 2004	$ 74,640.14
January – February 2005	$ 64,531.45
Total Billed	$ 230,966.92

Medicaid Managed Care Organizations (MCOs) had difficulty implementing the elevated payment formula for trauma care in FY 2004, but problems have now been resolved. Independent information provided by trauma physicians indicates that all MCOs paid at the elevated levels by March 2005. Obtaining estimated MCO payments from Medicaid has been more difficult as Medicaid accounting systems have only recently been modified to identify MCO elevated trauma payments. In August 2005, Medicaid reported to MHCC that the MCOs incurred about $174,000 in enhanced payments under the Fund for the months January 2004 through May 2005. The Fund will pay Medicaid about $87,000 in FY 2006 for elevated payments made by MCOs in the prior fiscal years. Future Fund obligations attributable to elevated MCO Medicaid payments will likely be quite low, as MCOs cover expectant mother and child populations -- groups that have historically not had significant trauma utilization.

Trauma payments to Medicaid have been significantly below expectations. MHCC believes traditional Medicaid and the MCOs are now appropriately making payments. Reconciliation of the elevated payments and reporting these amounts to MHCC was delayed in 2005 due to accounting system limitations. MHCC expects Medicaid's reconciliation process to improve in FY 2006, which will lead to speedily payments to Medicaid. Even with the recent payment system improvements, MHCC and Medicaid need to evaluate future Medicaid trauma funding needs given recent increases in Medicaid fees.

Payment to Children's National Medical Center for Standby Expense

The law allows the Fund to issue an annual grant of up to $275,000 to Children's National Medical Center (CNMC, Children's) for providing standby services that are used by Maryland trauma patients. MHCC approved a $206,250 payment to Children's in September 2004 for FY 2004 standby expenses.[5] The $206,250 reimbursed CNMC for the standby costs incurred from October 2003 through June 2004. Children's did not submit a standby application in January 2005, but will submit an application in the fall of 2005. Children's has reported difficulty documenting costs related to

[5] MHCC and HSCRC developed guidelines for an annual grant from the Maryland Trauma Physician Services Fund of up to $275,000 to subsidize the standby costs for Children's National Medical Center. The grant allows Children's National Medical Center to recover a certain level of standby costs incurred relative to Marylanders utilizing the trauma center. HSCRC determined that Children's standby expenses were in excess of the funding ceiling. Children's submits a grant application for standby that is similar in format to the applications used by Maryland trauma centers to document on-call expenses.

standby expenses as physicians that serve the trauma center are salaried. MHCC will continue to work with Children's to improve the application process while maintaining financial control.

HSCRC Standby Expense Allocation

On July 1, 2004, HSCRC included the standby costs incurred in having a trauma surgeon, orthopedic surgeon, neurosurgeon, and anesthesiologist in the trauma center in the FY 2005 reimbursement rates for hospitals with trauma centers. The total amount included in hospital rates for FY 2005 was approximately $4.1 million, which was based on hospital standby expenses reported to HSCRC in FY 2003. Table 6 represents the amount that each hospital received effective July 1, 2004 to reflect the reasonable standby costs incurred by trauma centers. The Commission used the Reasonable Cost Equivalent (RCE) methodology employed by Medicare in determining reasonable allowable standby costs. The amounts below are placed in the general rate base of each hospital and include an appropriate update (using Global Insights Medicare Economic Index) through the end of FY 2005. Future updates are applied to this revenue as part of the overall rate base. Standby allocation costs do not have any impact on the Fund because the additional expenses are incorporated into the approved rates that hospitals are allowed to charge third party payers.

Table 6- Maryland Trauma Center Standby Costs To be Place in HSCRC-Approved Rates for FY 2005

	Inpatient	Outpatient	Total $
Johns Hopkins Hospital	$ 639,172	$ 96,304	$ 735,477
Prince George's Hospital Center	1,170,713	33,724	1,204,437
Sinai Hospital	468,060	390,766	858,826
Suburban Hospital	329,750	155,176	484,926
Peninsula Regional Medical Center	-	-	-
Washington County Hospital	381,261	187,785	569,046
Western Maryland Health System	228,042	47,039	275,081
Total	$ 3,216,999	$ 910,795	$ 4,127,794

Note: Peninsula Regional Medical Center reported no standby costs in FY 2003.

Outlook for Future Revenue and Disbursements

MHCC estimates the balance in the Fund will grow in FY 2006. Over the first 2 years of Fund operation, the Fund built a $15 million dollar balance. Adjusting for lags in reporting uncompensated care, Medicaid payments, and on-call payments, but not explicitly factoring in possible Medicaid under-reporting yields a $12.4 million balance for the fall of 2005. The expected balance using similar financial assumptions for the future and assuming no changes in current law would place the Fund balance at $18 million at the end of FY 2006 with an actual year end closing balance of $21 million. Factors that will contribute to changes in the Fund balance are briefly discussed in the following section.

On-call payments will trend upward over the next year. Under current law, the Fund is obligated to pay up to $5.1 million in on-call payments for calendar year 2005. Inflation in physician fees that are explicitly factored into yearly adjustments will increase the ceilings by 2-4 percent in the future. For calendar year 2006, MHCC estimates that the ceiling for on-call payments will climb to $5.2 million. MHCC expects that more practices will negotiate on-call payments in contracts with trauma centers. Payments for trauma calls will be well below the payment ceilings; MHCC expects that on-call payments will total about $3.7 million in FY 2006. Reimbursements will not reach the maximum available to each center without legislative changes to expand the number of specialties eligible for on-call payments.

A staffing change at some Level II centers will modestly affect on-call payments. Most Level II centers have started to staff their centers, at least part-time, with a 4th year surgical resident and a trauma surgeon to take trauma calls. This practice lowers the cost of maintaining a trauma center during off-peak hours by reducing standby expenses, but it also increases on-call payments. The Level II trauma centers that employ this practice report on-call payments to trauma physicians in the range of $25,000-$75,000, compared to a ceiling maximum in excess of $175,000.

External factors such as the percent of the population that is uninsured and the rapid growth in emergency services affect uncompensated care levels and make forecasting the future of compensated care disbursements more uncertain. A growing number of uninsured will drive the trauma uncompensated care payments higher. Over the past several years, Maryland, like the rest of the country, has seen modest increases in the uninsured. Improved triaging of trauma by emergency

medicine personnel and by emergency departments could increase the number of patients that arrive at trauma centers. MIEMSS reports that the number of trauma cases has increased by 5.4 percent from 2003 to 2004.[6]

Increased awareness of the Fund and trauma staffing changes are likely to have a modest impact on Fund balances. Some trauma centers pointed out that access to the Fund is not universal. As awareness grows, applications will increase. MHCC agrees that some medical practices may not apply for reimbursement, but these practices are not primarily trauma practices. The addition of these practices will have a negligible impact on the fund balance. Increased use of emergency medicine physicians at Level II and Level III centers could increase total payments. However, current payments are near the statutory limit of $250,000 and legislative action is needed if the Fund is reimbursed above the current limit.

Trauma Fund payments to physicians participating in the Medicaid program will decrease in the future due to the fee increases mandated in the Maryland Patients' Access to Quality Health Care Act of 2004 (HB 2 adopted in the 2004 Special Session). On July 1, 2005, the Medicaid program raised physician fees to 100 percent of the Medicare rate for commonly performed orthopedic and neurosurgical procedures. Reimbursement for five commonly performed evaluation and management (E&M) emergency department procedures also increased. As a result of these fee changes, the Fund will not have an obligation to pay the difference between Medicare and Medicaid fees. MHCC raises a note of caution on this issue because it is not precisely known what the current Medicaid demands on the Fund are, and it may take some time for MCOs and traditional Medicaid to reconcile all trauma services. The impacts of fee changes on the Fund, although modest, remove some of the uncertainty about the level of Medicaid payments, and allow for better Fund management. Trauma and anesthesiology services provided via Medicaid remain at historic levels, which range from 40 to 75 percent of the Medicare fee. Medicaid is currently devising plans to raise physician fees to 100 percent of the Medicare rate for all services. If implemented, the Fund will have no Medicaid obligations.

The trend toward greater use of physician on-call means that the share of Fund obligations attributable to on-call payments will increase. For FY 2005, physician on-call payments accounted for 51 percent of total Fund payments. On-call payments account for 60 percent of unpaid obligations incurred in FY 2005, but paid in FY 2006. Absent legislative changes, it is likely that on-call will continue to increase

[6] Maryland Institute for Emergency Medical Services Systems, ***Annual Report 2003-2004***, Baltimore, MD page 46.

until payment ceilings are met. The MHCC notes that the original legislation balanced concerns of many groups that support the Maryland trauma system, with no single disbursement mechanism dominant. Trauma specialists at large urban trauma centers benefit via the payments for uncompensated care and elevated payments for Medicaid. Physicians at smaller trauma centers benefit through on-call payments and the adjustments for trauma center standby expenses that are added to HSCRC-approved rates. The statute recognized the important role of emergency medicine in supporting the system and the services provided by out-of state trauma centers that are part of the Maryland Trauma System. As actual disbursements among the groups have not tracked exactly with the estimates, some refinements in the payment formula are appropriate to maintain balance among the groups that serve the system.

Options for Expanding the Fund Reimbursement

The current balance in the Fund suggests that eligibility for participation could be expanded without impacting trauma centers or providers now participating in the Fund. During August and September, MHCC staff met with TraumaNet[7], individual trauma centers, physicians, other stakeholders, and MIEMSS to discuss possible options for expanding disbursements. The options presented below represent possibilities for increasing disbursements from the Fund or, in one instance, slowing the pace of collections via the MVA. MHCC and HSCRC are not endorsing a specific set of options at this time, as our primary role is providing information on the alternatives.

The options that follow are organized according to primary revenue flow under the current system: (a) uncompensated care, (b) on-call payments, (c) payment to Medicaid for raising trauma fees to 100 percent of Medicare, and (d) other administrative changes. Each proposal is briefly summarized and an initial fiscal impact is provided. For some options, MHCC can identify the direction but not the magnitude of the increase. Further refinement of the estimates will be made later in the fall.

Options to Expand Uncompensated Care

1. Expand the number of physicians eligible to submit an uncompensated care application by adding all trauma physician specialties.

[7] TraumaNet, the consortium of trauma providers, submitted a prioritized list of recommendations to MHCC that is included in Appendix 5.

Six physician specialties are eligible to participate in the Fund. The Maryland Institute for Emergency Medical Services Systems (MIEMSS) identifies twenty-two other surgical and non-surgical physician specialties that should be on-call and available to respond. These specialties are part of trauma teams at trauma centers in Maryland. Although these specialties are not required in every trauma case, their services are critical to properly treat certain injuries. Allowing the specialties listed below to submit uncompensated care claims would establish parity across all specialties that serve trauma patients.

Surgical Specialties	Medical Specialties
• Cardiac	• Cardiology
• Hand	• Pulmonary medicine
• Microvascular replant or flaps	• Radiology
• Obstetric and gynecologic	• Gastroenterology
• Ophthalmic	• Infectious Disease
• Oral or maxillofacial	• Internal Medicine
• Otolaryngology	• Nephrology
• Pediatric	• Neurology
• Plastic	• Pathology
• Thoracic	• Pediatrics
• Urologic	• Psychiatry

Fiscal Impact: Uncompensated care payments will total about $2 million in FY 2006. The addition of twenty-two specialties will increase payments for specific patients significantly. However, the magnitude of the overall impact is not clear. MHCC's preliminary estimate is that this expansion will increase Fund payments by $1 million. More data is needed to improve the precision of this estimate. TraumaNet has agreed to provide information on the use of these specialties. MHCC intends to refine the estimate after analyzing the specialty utilization and cost data from TraumaNet.

2. Remove the $250,000 cap on payments to emergency room physicians. The amount of payment to emergency room physicians for services provided to uncompensated care patients is capped at $250,000 annually because of uncertainty regarding the availability of funds.

Fiscal Impact: Emergency medicine uncompensated care payments are increasing as awareness increases. Current and future balances in the Fund are adequate to support the expected level of uncompensated care provided by emergency medicine physicians working at trauma centers. Disbursements for emergency medicine will climb to approximately $265,000 in FY 2006, an increase of about 18 percent.

3. Allow a certified registered nurse anesthetist (CRNA) working under the medical direction of an anesthesiologist to bill the Fund. Level II and III trauma centers use CRNAs that are employed by the hospital. Under current law, only an anesthesiologist can be reimbursed for services to uncompensated care patients. CRNAs are integral to providing anesthesiology services to patients in the trauma center. When medically appropriate, allowing CRNAs to bill would ensure that hospital-based staff is used efficiently to care for uninsured (uncompensated care) patients.

Fiscal Impact: The Fund reimbursed anesthesiologists about $100,000 in FY 2005 for direct services and management of CRNAs. Allowing centers to bill for CRNA services will benefit Level II and III centers. MHCC assumes that this change could, at the maximum, double anesthesiology payments under the Fund. MHCC believes that small offsetting savings could occur if some centers substitute a CRNA for anesthesiologist's services, as CRNAs are reimbursed at a lower rate under Medicare.

4. Expand the definition of trauma care to include patients seen at specialty referral centers. The inclusion of physicians at the burn and hand specialty referral centers would allow physicians to receive payment for uncompensated services provided at the Baltimore Regional Burn Center at Johns Hopkins Bayview Medical Center, for patients with traumatic hand injuries at the Curtis National Hand Center at Union Memorial Hospital, and for care provided at the Wilmer Eye Institute at Johns Hopkins Hopkins. In FY 2004, the Baltimore Regional Burn Center treated 389 patients. No data are available on utilization at the Hand Center and Eye Institute. No data on insurance status is currently available for any of the facilities.

Fiscal Impact: The impact of burn care could be significant as severe cases are extremely expensive to treat. MHCC will work with MIEMSS and TraumaNet to obtain estimates on the costs of physician service at these centers. The specialty centers do not currently report to the MIEMSS Trauma Registry at present. If uncompensated care is covered, a reporting protocol would need to be developed. These changes would require modifications to MIEMSS regulations.

Options to Expand On-Call Payments

1. Raise Level II trauma centers to 30 percent of Medicare reasonable compensation equivalent (RCE). The Fund reimburses Level II and III trauma centers for incurring on-call costs using a prescribed formula based on a percentage of the RCE hourly rate for a physician specialty, and an inflation factor tied to the physician compensation component of the Medicare Economic Index.

Payments are capped at 20 percent and 30 percent of the RCE for Level II and Level III trauma centers, respectively. An increase in the RCE hourly rate percentage will increase the amount that the Fund reimburses each Level II trauma center for on-call expenses. Several Level II centers argued for a funding level on par with Level III centers, as they maintain that on-call stipends are higher in urban settings.

Fiscal Impact: The cumulative impact of raising the Level II trauma centers on-call ceiling is approximately $1 million per year. Ceilings for on-call payments for Level II centers will increase up to $270,000 per center from approximately $542,000 to $812,000. These ceilings will remain theoretical maximums for several years, as it is unlikely that any Level II center will raise on-call payments. MHCC expects that centers will reach the payment ceilings in the next several years as practices become more aware of the maximum amounts.

2. Remove the specialty-specific ceilings and allow trauma centers to obtain payment for on-call with no limitation on specialty eligibility. Trauma centers operate in several different physician markets. Supply of particular specialties can vary among the markets, with plastic surgeons being in short supply in one market, and orthopedists in another. Removing the limit on specialties could allow a hospital to respond to local conditions more efficiently. If a hospital needs to offer on-call stipends to maintain access to a trauma specialty, it could do so and these costs would be reimbursed up to the limit established in the law. If there is a pressing need for a particular specialist, the trauma center would have flexibility in using on-call to attract and retain the physician. All specialties listed below are recognized in MIEMSS regulations and could be eligible for on-call payments.

Current Trauma Specialties Eligible for On-call	
• Anesthesiology (Level III only)	• Trauma Surgery
• Orthopedics	• Neurosurgery

Other Specialties Identified In MIEMSS Regulations	
• **Surgical Specialties**	• **Medical Specialties**
• Cardiac	• Cardiology
• Hand	• Pulmonary medicine
• Microvascular replant or flaps	• Radiology
• Obstetric and gynecologic	• Gastroenterology
• Ophthalmic	• Infectious Disease
• Oral or maxillofacial	• Internal Medicine
• Otolaryngology	• Nephrology
• Pediatric	• Neurology
• Plastic	• Pathology
• Thoracic	• Pediatrics
• Urologic	• Psychiatry

Fiscal Impact: This option would increase on-call payments reimbursed through the Fund assuming no change in the overall on-call ceilings. As previously noted, Level II are eligible for approximately $542,000 and Level III centers are eligible for up to $1.056 million in calendar year 2005. Expanding the specialties for which a trauma center can obtain on-call payments from the current four to twenty-six would virtually guarantee that all centers would reach the on-call ceilings. Payments would total approximately $5.2 million for on-call in FY 2006, up from a projected $3.7 million under current law. If the on-call payment formula for Level II is raised, as described in Option 1.a, total on-call spending could climb to about $6.3 million.

Several cautions should be recognized if the General Assembly considers this approach: (1) no generally accepted guidelines exist for on-call payments; (2) expanding on-call payments will institutionalize these expenses in the hospital's budget. If the Fund were to sunset, it is likely that the trauma centers would be obliged to pay on-call; and (3) a broad precedent established to meet trauma needs would likely spread to other non-trauma on-calls.

3. Raise Children's National Medical Center's Standby Allowance. Children's receives a grant for standby expenses because it can not include standby expenses associated with serving Maryland pediatric trauma patients in its hospital rates. The Grant establishes a mechanism for Children's to obtain support for standby at a level similar to that received by Maryland hospitals.

Fiscal Impact: Children's reported half a million dollars in standby expenses in its initial filing for standby payments. MHCC expects that Children's will apply for a grant of $275,000 in 2005. MHCC assumes that every dollar added to the grant will be used. Maintaining parity with Maryland hospitals may be a benchmark for establishing the grant level. Total standby costs allowed for all Maryland hospitals with trauma centers was $4.1 million or approximately $590,000 per hospital in FY 2005. The average standby expense reflected in hospital rates would be a method for defining the ceiling on Children's standby grant. If this assumption is used, Children's grant ceiling could be set at $590,000.

Options to Change Medicaid Payments

1. Increase trauma physician fees to 100 percent of Medicare and finance the increase via a transfer from the Trauma Fund. Medicaid accounts for a very small share of Fund disbursements, yet accounts for a significant amount of Fund administrative expenses. Medicaid unilaterally raised fees in July 2005 for two of the current trauma specialties. Under current law, disbursements to Medicaid will decline. Although some underreporting may be an issue, Trauma Fund transfers to Medicaid have totaled less than $500,000 over the past 18 months. (This figure includes incurred costs that the Fund will reimburse in FY 2005.) The administrative expense associated with implementing these changes has been significant to Medicaid and the MCOs. Given that the disbursements to Medicaid are small, using the Trauma Fund dollars to raise Medicaid fees to 100 percent of Medicare could produce a more efficient administrative process. Using the Fund dollars to increase trauma related services would be an imprecise process, but once accomplished it would eliminate a process that up to now has been cumbersome for all agencies. Medicaid could provide the Fund with a list of codes that are routinely provided in trauma centers. The cost of these services would be estimated and agreed to by MHCC and HSCRC via an MOU. The Fund would then transfer the funds needed to eliminate the differential between Medicaid and Medicare. MHCC expects that this change will not affect overall disbursements, although administrative savings could result.

Fiscal Impact: This change would have little fiscal impact because payments are already being made under current law. An equivalent amount adjusted for inflation could be transferred from the Fund to Medicaid to raise disbursement to 100 percent of Medicare. MHCC assumes Medicaid payments would not exceed $500,000. Administrative efficiencies will result because the need to reconcile funds across multiple agencies will disappear.

Other Possible Administrative Changes

1. Give the MHCC and HSCRC greater flexibility in defining the methodology. Current law states that the MHCC and HSCRC are responsible for defining the methodology taking into account: (a) the amount of physician uncompensated care and Medicaid under-compensated trauma care; (b) the cost of maintaining trauma physicians on-call; and (c) the number of patients served by trauma physicians in trauma centers. The Commissions are further directed to include an incentive to encourage hospitals to continue to subsidize trauma-related costs not otherwise included in hospital rates. The law is very specific on how these concerns should be met. Given that Fund balances change, more flexibility in developing the methodologies will lead to more efficient Fund administration. The original bill envisioned that the Commissions would have flexibility in designing a payment methodology; however SB 429, as enacted, provided more specificity than is probably desirable.

The following changes are possible:

- Allow the Commission to define the period and the place of service for trauma care. Currently the Fund reimburses trauma services provided during the initial hospital visit. The Commissions should have the authority to allow the Fund to reimburse for subsequent inpatient admissions or outpatient visits provided by trauma physicians. Similarly, trauma services often extend to post-acute and ambulatory settings where care can be more efficiently provided.
- Allow the Commissions to set the payment level for uncompensated care and on-call services. The statute defines ceilings on reimbursements for uncompensated care as 100 percent of Medicare and sets on-call ceilings as a percent of Medicare RCE payment methodology.

The following table provides the impact to the Fund of on call payments when the reasonable cost equivalent hourly rate for the physician specialty increases.

On-Call Payment Totals
Adjusted Payment Projections

%RCE	Non-Metropolitan areas (Cumberland & Salisbury)	Metropolitan areas less than one million (Hagerstown)	Metropolitan areas greater than one million (Baltimore & Washington)	Total
CY2004	$ 904,891	$ 1,026,689	$ 525,600	$ 2,457,180
30%	$ 904,891	$ 1,026,689	$ 788,400	$ 2,719,980
35%	$ 1,055,706	$ 1,197,804	$ 919,800	$ 3,173,310
40%	$ 1,206,522	$ 1,368,918	$ 1,051,200	$ 3,626,640
45%	$ 1,357,337	$ 1,540,033	$ 1,182,600	$ 4,079,970
50%	$ 1,508,152	$ 1,711,148	$ 1,314,000	$ 4,533,300

The following table provides the impact to the Fund when the amount of uncompensated care payments increases as a result of changes in the uncompensated care rate relative to Medicare fees.

Uncompensated Care Payment Totals
Adjusted Payment Projections

Payment Increase	Total
Period 2 2005	$ 2,100,000
105%	$ 2,205,000
110%	$ 2,310,000
115%	$ 2,415,000
120%	$ 2,520,000
125%	$ 2,625,000
130%	$ 2,730,000

The ability to adjust payment levels, perhaps within a narrow range, would allow the Commissions more flexibility to manage the Fund balance. Raising reimbursement modestly when large balances occur, and lowering fee levels when balances are smaller, would eliminate the need to make statutory changes when balances rise or fall.

Fiscal Impact: These proposals do not have an automatic cost or savings as MHCC assumes that the Commission would prudently adjust payment levels according to Fund status.

2. MVA Collection Reduction Option. Some analysts argue that current disbursements meet the needs identified in 2003. Rather than increasing the number of eligible providers or raising fee levels, these individuals argue that MVA registration renewal fees should be reduced to align collection with current needs. The existing surplus ($12 million) would be to reimburse for unexpected heavier demand.

Fiscal Impact: A 20-percent reduction in renewal costs would reduce payments by $1 per automobile owner and decrease revenue in FY 2005 from $11.6 million to $9.3 million. A 40 percent reduction would reduce total MVA collection to $7 million. This reduction could be implemented on a temporary or permanent basis depending on whether the General Assembly wished lower the existing Fund balance or precisely align collections with existing needs.

Overall Fiscal Impact

The total estimated cost of all options is approximately $4.8 million. Table 7 presents a comparison of estimated costs for all the options. The estimates are based on increases above expected FY 2006 spending levels. The new options and current law disbursements will bring total spending to about $11 million. Collections from the MVA will total approximately $11.7 million during the same period.

Estimates need to be viewed cautiously. Data limitations affect the precision of the uncompensated care estimates. MHCC does not have significant information on the use of other trauma specialists or the cost of care at specialty referral centers. On-call estimates assume that hospitals will obtain the maximum allowable from the Fund. During the next several months, MHCC will work with the trauma providers to improve the precision of these estimates.

Table 7 Estimated Cost to the Trauma Fund of Proposed Legislative Options

(Preliminary)

Option	Estimated Additional Annual Costs to Fund [1]
Options to Expand Uncompensated Care Payments	
1. Expand the number of physicians eligible to submit an uncompensated care application by adding all trauma physician specialties	$1,000,000
2. Remove the $250,000 cap on payments to emergency room physician	$ 50,000
3. Allow certified registered nurse anesthetist (CRNA) working under the medical direction of an anesthesiologist to bill the Fund	$ 100,000
4. Expand the definition of trauma care to include patients seen at specialty referral centers.	$ 500,000
Options to Expand On-Call Payments	
1. Raise Level II trauma centers on-call ceiling to 30 percent of Medicare reasonable compensation equivalent (RCE).	$1,040,000
2. Remove the specialty-specific ceilings and allow trauma centers to obtain payment for on-call with no limitation on specialty eligibility.	$1,500,000
3. Raise Children's National Medical Center's Standby Allowance.	$ 250,000
Options to Change Medicaid Payments	
1. Increase trauma physician fees to 100 percent of Medicare and finance the annual fee update via a transfer from the Trauma Fund. [2]	($ 25,000)
Other Possible Administrative Changes	
1. Give the MHCC and HSCRC greater flexibility in defining the methodology.	$ 350,000
Total Additional Fund Disbursements	$ 4,765,000
Estimated Trauma Fund Disbursements Under Current Law in FY 2006	$ 6,200,000
TOTAL DISBURSEMENT UNDER CURRENT LAW AND PROPOSED CHANGES	$10,965,000
ESTIMATED FY 2006 COLLECTIONS	$11,700,000
MVA Collection -- Reduce in fees from $5 to $4 on a registration or registration renewal	($ 2,300,000)

Note: (1) Additional costs are in excess of payments the Fund is expected to make in FY 2006; (2) no reductions have been made in Fund disbursement for attributable to increases in the Medicaid Fee Schedule for orthopedic, neurosurgical, and emergency medicine procedures required under Maryland Patients' Access to Quality Health Care Act of 2004.

Appendices

Appendix Table 1 – Maryland Motor Vehicle Registration Fees Collections per Month

Total FY 2004	$ 10,441,648.88
July 2004	861,176.66
August 2004	1,026,353.50
September 2004	936,956.13
October 2004	1,019,112.32
November 2004	932,328.44
December 2004	828,987.93
January 2005	843,564.44
February 2005	835,202.72
March 2005	1,028,047.58
April 2005	1,031,420.87
May 2005	1,010,518.10
June 2005	1,301,694.64
Subtotal—YTD	11,655,363.33
TOTAL	$ 22,097,012.21

Note: Monthly totals include interest earned during the month.

Appendix Table 2 --Maryland Trauma Physician Services Fund

Uncompensated Care Payments Made in FY2005

TRAUMA PHYSICIAN/GROUP	FY2005
Andre Gazdag, M.D./BCCOA	$ 3,239.82
Bijan Bahmanyar, M.D.	57,086.00
Bethesda Emergency Associates, LLC (ED)	2,585.04
Betsy Ballard, M.D.	24,029.93
Boyd E. Sprenkle, M.D.	918.99
Brajendra Misra, M.D.	27,487.37
Center for Joint Surgery and Sports Medicine	1,910.07
Cumberland Anesthesia & Pain Management Assoc, PC	727.25
Cumberland Emergency Medical Group, PA (ED)	1,718.02
Drs. Falik & Karim, PA	24,246.25
Eastern Shore Orthopaedics	2,676.43
Emergency Services Associates, PA	6,953.07
Enrique Daza, M.D.	20,537.62
Ernest Hanowell, M.D.	7,061.12
Harvey Shapiro, M.D.	71,449.44
Jeffrey Muench, M.D.	53,350.84
Johns Hopkins Adult Trauma Center	274,418.61
Johns Hopkins Adult Trauma Center (ED)	125,622.83
Johns Hopkins Bayview Medical Center	50,726.95
Johns Hopkins Bayview Medical Center (ED)	34,521.49
Johns Hopkins Pediatric Trauma Center	21,602.18
Johns Hopkins Pediatric Trauma Center (ED)	14,631.63
Lifebridge – Trauma	9,969.09
Mark A. Sagin, M.D.	766.36
Memorial Hospital Orthopedic Group	930.02
Montague Blundon, III, M.D.	17,787.84
Neurosurgical Specialists, LLC	18,018.56
North American Partners in Anesthesia-MD	11,797.33
Peninsula Neurosurgical Associates	16,607.74
Peninsula Orthopaedic Associates, PA	19,366.89
Peninsula Pulmonary Associates, PA	3,738.05

PGHC Anesthesia Associates	1,073.52
PGHC Critical Care Center	10,207.97
PGHC Trauma Associates	2,672.50
Ramin M. Jebraili, M.D.	6,709.78
Robinwood Orthopedic Specialty Center	12,830.61
Sagar V. Nootheti, M.D.	44,290.40
Said A. Daee, M.D.	64,826.84
Sinai Faculty Practice Plan	58,470.16
Sylvanus Oyogoa, M.D.	11,588.06
Trauma Services (Cumberland)	744.20
Trauma Surgery Associates (Bethesda)	18,256.49
Trauma Surgical Associates (Salisbury)	47,953.03
University Physicians, Inc.	428,563.14
Washington County Emergency Medicine Physicians	15,963.68
Washington County Hospital Trauma Physicians	30,164.67
Willie C. Blair, M.D.	45,356.98
Western Maryland Trauma Associates, PA	2,596.84
Yardmore Emergency Physicians	23,987.50
Application Total	$ 1,752,739.20
Prior Period Recovery Adjustments	(69,765.78)
Disbursement Amount	$ 1,682,973.42

Appendix Table 3 – On call Maximum Payments for CY 2004

Maximums for On call Payments based on CMS Reasonable Compensation Equivalents as of August 1, 2003			
Specialty	**Non- Metropolitan (Cumberland & Salisbury)**	**Metropolitan Areas less than one million (Hagerstown)**	**Metropolitan Areas greater than one million (Baltimore-Washington)**
Level II Trauma Centers			
Neurosurgery			$132,000
Orthopedic Surgery			$132,000
Trauma Surgery (for Sinai and Johns Hopkins Bayview only)			$132,000
Level III Trauma Centers			
Anesthesiology	$159,447	$190,670	
Neurosurgery	174,107	194,288	
Orthopedic Surgery	174,107	194,288	
Trauma Surgery	174,107	194,288	
TOTAL	**$681,768**	**$773,534**	**$396,000**

Note: All computations assume that a specialty provides 8,760 hours of on call coverage during a year. If a trauma center pays for less than 8,760 hours, the rate is adjusted by the hours actually paid.

Appendix Table 4 --Maryland Trauma Physician Services Fund

On Call Payments Made in FY2005

Trauma Facility	Anesthesia	Neurosurgery	Orthopedic Surgery	Trauma Surgery	Payment Adjustments	On call Total
	FY2005	FY2005	FY2005	FY2005	FY2005	FY2005
Johns Hopkins Bayview Medical Center	$	$ 132,000	$ 132,000	$ 84,960	$ (146,639.82)	$ 202,320.18
Peninsula Regional Medical Center	156,680	114,999	114,998	174,265	320.39	561,262.39
Prince George's Hospital Center		132,120	131,520		480.11	264,120.11
Sinai Hospital of Baltimore		132,120	127,200	60,514	(61,669.88)	258,164.12
Suburban Hospital			116,160		(6,959.94)	109,200.06
Washington County Hospital Association		194,464	194,464	194,258	1,059.21	584,245.21
Western Maryland Health System		169,516	36,191	157,012	(41,692.95)	321,026.05
TOTAL	$ 156,680	$ 875,219	$ 852,533	$ 671,009	$ (255,102.88)	$ 2,300,338.12

Appendix 5

TRAUMANET RECOMMENDATIONS
for
SENATE BILL 479 MODIFICATIONS

Prioritized List

1. Expand the “trauma physician” definition to include **all** physicians who provide trauma care to trauma patients.

2. Expand the “trauma center” definition to include the Maryland Specialty Referral Centers (Burn, Hand and Eye).

3. Increase the caps for Level II and Level III trauma centers to maintain physician’s on-call.

4. Expand the time period to include follow-up trauma care related to the original injury for no more than one year. This would include inpatient care and outpatient surgery only.

5. Increase the caps for ED physicians and DC Children.

6. Include CRNA’s as eligible trauma care providers to submit for reimbursement for uncompensated/under-compensated trauma care patients.