MARYLAND TRAUMA PHYSICIAN SERVICES FUND

Health General Article § 19-130

Operations from July 1, 2005 through June 30, 2006

To The

MARYLAND GENERAL ASSEMBLY

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This annual report on the Maryland Physicians Trauma Services Fund for fiscal year 2006 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.

Summary

The Maryland Physician Trauma Fund (Trauma Fund, 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 2006, the MVA collected $12.5 million from the $5 surcharge on motor vehicle renewals. The Trauma Fund paid trauma physicians and trauma centers $7.2 million for providing uncompensated care, Medicaid under-compensated services, and trauma on-call expenses. The Fund also held $4.2 in claims that were incurred, but not paid until FY 2007. The balance in the Trauma Fund stood at about $20.8 million at the end of FY 2006 or $16.5 million if incurred, but not paid obligations, are netted against the Fund.

Disbursements from the Trauma Fund to trauma providers will increase significantly beginning in FY 2007. HB 1164 (Trauma Reimbursement and Grants), passed in the 2006 session of the Maryland General Assembly, increases the specialties that are eligible for uncompensated and Medicaid under-compensated care and raises the on-call reimbursement formula for trauma centers. Trauma physicians at three specialty referral centers become eligible for uncompensated care reimbursement and elevated Medicaid payments. The legislation further directs the MHCC to award equipment grants totaling $3 million from the balance in the Trauma Fund at the end of FY 2006. These expansions will more closely align collections from the MVA with disbursements from the Fund. MHCC expects the trauma equipment grant program to reduce the balance in the Fund by $3 million as all eligible trauma centers report significant unfunded equipment needed related to trauma.

MHCC does not believe further changes in the distribution formula or eligibility criteria for the Trauma Fund are warranted in 2007. At least one year is needed to fully implement the changes enacted through HB 1164.

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 allow trauma center hospitals to include trauma-related standby expenses in HSCRC-approved hospital rates. In FY 2004 and FY 2005, the Trauma Fund reimbursed physicians and trauma centers for about $7 million in the trauma-related expenses. The MVA collected over $22 million in revenue during FY 2004 and FY 2005. By the end of FY 2005, the balance had grown to $15.5 million. When claims incurred, but not paid were netted against the Fund, the balance stood at $12.4 million at the end of FY 2005.[3]

A sizeable balance in the Fund developed for three reasons. First, the initial eligibility criteria were intentionally limited. Specialties that commonly provided trauma care were the only specialties eligible reimbursement for the uncompensated care and Medicaid under-payment from the Fund. Second, thresholds for on-call payments were designed to partially cover total on-call expenses. This is consistent with the language in the law which directs the MHCC to continue to provide incentives to trauma centers hospitals to cover trauma center costs. Lastly, MHCC overestimated the funds needed to raise Medicaid payments to 100 percent of Medicare.[4] In the last 3 years, payments to Medicaid to account for the difference between the Medicare and the Medicaid rates have totaled only about 25 percent of the original estimate. Beginning in 2006, the Medicaid program increased fees for a number of specialties and as a result the under-

[1] COMAR 10.25.10 originally defined trauma physicians as trauma surgeons, anesthesiologists, orthopedic surgeons, neurosurgeons, critical care physicians, and emergency room physicians to conform with the statutory definition.

[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 may operate with all trauma physicians on call, although a center is permitted to have physicians on standby. Level III 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] Physician practices and trauma centers submit applications for reimbursement biannually on January 31st and July 31st for the previous 6 month period. The 6 month reporting lag means that services provided in the last half of each fiscal year are paid in the following fiscal year. The MHCC nets these disbursements against the Fund balance to provide a complete picture of financial status.

[4] MHCC had access to limited data on Medicaid under-payments from only one trauma center in 2003.

payments have declined, further reducing the Trauma Fund's obligations. Medicaid fees for emergency medicine and orthopedics are now about 100 percent of the Medicare fee in Maryland.

Recognizing that expanding eligibility to the Fund was prudent, the MHCC identified eight options for expanding the fund in the FY 2005 Trauma Report.[5] The Maryland General Assembly passed and Governor Robert Ehrlich signed legislation that significantly expanded the number of physicians that could receive payment from the Fund in 2006. These new laws became effective July 1, 2006 and MHCC adopted regulations (COMAR 10.25.10) to implement the new law in the summer of 2006. The impact of these changes is discussed in the "Future Outlook" beginning on page 12 of this report. Changes enacted in HB 1164, however, have no impact on the balance at the end of 2006.

Status of the Fund at the End of FY 2006

The Trauma Fund disbursed about $7.2 million to trauma centers and trauma physician practices in 2006. Table 1 summarizes the revenues, disbursements, and the Fund balance at the end of FY 2006.

Table 1 - Trauma Fund Status on a Cash Flow Basis

CATEGORY	AMOUNT
Fund Balance Start of FY 2006 (July 1, 2005)	$15,483,553
MVA Collections in FY 2006 from the $5 Registration Fee	12,553,359
2006 Collections and Previous Year Balance	28,036,912
-- Uncompensated Care Payments	-2,646,319
-- On-Call Expenses	-3,748,065
-- Medicaid Payments through 05/01/06	-536,115
-- Children's National Medical Center Grant for Standby Expenses	-275,000
-- Audit Expenses	-62,706
Credit From FY 05 Encumbrances and 2006 Corrections	25,930
Total Outlays for FY 2006	-$7,242,275
TRAUMA FUND BALANCE END June 30 2006	$20,794,637

[5] Maryland Health Care Commission, ***Maryland Trauma Physician Services Fund: Operations from July 1, 2004 through June 30, 2005***, September 2005

Collections by the MVA via the $5 surcharge grew from about $11.6 to $12.5 in 2006, a 7.8 percent increase. At the end of fiscal year, the Fund balance stood at $20.8 million, up from roughly $15.4 million in 2005.

Outstanding Obligations for FY 2006

The Fund held outstanding obligations that totaled approximately $4.2 million , which are not reflected in the FY 2006 year end balance. These obligations result from provider applications submitted in July 2006 for services provided in FY 2006. A reconciliation of these applications leaves a Fund balance of $16.6 million after all obligations are paid for FY 2006. The $4.0 million in uncompensated and on-call payments are the highest made by the Fund in any bi-annual filing period. MHCC attributes this increase to increased awareness about the Fund, rather than skyrocketing uncompensated care. For example, several smaller trauma and critical care practices submitted uncompensated care applications for services provided over the entire previous 2 fiscal years. The obligations shown in Table 2 do not include any obligations from Medicaid for the period from May and June 2006. These obligations could be in the range of $200,000-$300,000.

Table 2 – FY 2006 Obligations Incurred after Year End

TRAUMA FUND BALANCE END June 30, 2006	$20,794,637
Uncompensated Care Incurred, but not Paid by June 30, 2006	-1,981,343
On-call Incurred ,but not Paid by June 30, 2006	-1,980,471
Children's National Medical Center FY 2006 Standby Expenses	-275,000
TOTAL INCURRED, BUT NOT PAID IN 2006	-4,236,814
2006 BALANCE LESS INCURRED COSTS	$16,557,823

Payment to Practices for Uncompensated Trauma Care

Uncompensated trauma care services are reimbursed at 100 percent of the Medicare rate for that service in the Baltimore area pricing locality. Before applying for uncompensated care, a practice apply its routine collection polices by confirming that the patient has no health insurance and billing the patient. If the patient is uninsured and full payment (100 percent of the Medicare fee or more) is not received from the patient, 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. Table 3 presents the distribution of uncompensated care by the trauma center in which the care was provided. Payments to physicians practicing at Prince George's County Hospital Trauma Center accounted for almost 28 percent of all trauma uncompensated care in 2006. The large share of uncompensated care funds paid to physicians practicing at Prince George's is the result of two factors. First, the number of uninsured trauma patients is high, relative to other centers. Second, a number of physicians practicing at Prince George's Hospital Center delayed uncompensated care applications until FY 2006. These physicians received reimbursement for services provided in 2004 and 2005 during FY 2006.

Table 3 -- Uncompensated Care Trauma Fund Payments To Trauma Physicians by Trauma Centers

	FY 2006	
Facility	Payments	Share of Uncompensated Care Payments
Prince George's Hospital Center	$734,342.46	27.7%
Johns Hopkins Hospital Adult Trauma Center	$492,837.85	18.6%
R. Adams Cowley Shock Trauma Center	$409,496.43	15.5%
Suburban Hospital	$293,327.05	11.1%
Peninsula Regional Medical Center	$187,814.16	7.1%
Sinai Hospital	$171,266.71	6.5%
Johns Hopkins Bayview Medical Center	$169,773.44	6.4%
Washington County Hospital	$108,124.37	4.1%
Johns Hopkins Medical Center Pediatric Trauma Center	$59,489.88	2.2%
Western Maryland Health System	$19,847.14	0.7%
Total	$2,646,319.49	100.00%

Payment for Services Provided to Medicaid Enrolled Patients

This was the first year that the Medicaid administration reported a significant volume of Medicaid trauma care spending. Trauma care provided to Medicaid patients is reimbursed at 100 percent of the Medicare Baltimore locality rate, instead of the standard Medicaid rate. The Trauma Fund is responsible for 50 percent of the difference between the Medicare rate and the standard Medicaid rate with the federal government responsible for the other 50 percent. As shown in Table 4, a significant portion of the reimbursement to the program is for services delivered in FY 2005. MHCC anticipates that the program will continue to encounter significant delays in reporting to the Trauma Fund on money owed These delays are attributable to the small amount of money involved and the complexity associated with identifying trauma services that are eligible for reimbursement from the Trauma Fund.

Table 4 – Trauma Fund Payments to Medicaid

Service Period	Amount Billed
March - May 2005	$99,274
January 2004 - May 2005 Payments to MCOs	$87,222
June - October 2005	$194,256
November 2005 –February 2006	$94,677
March - April 2006	$60,686
Total Billed	$536,115

Note: In FY 2005, the Trauma Fund disbursed approximately $231,000 to the Medicaid Administration.

Payment for Trauma On-Call Service

Hospitals reimburse physicians for taking call or serving standby.6 On-call and standby payments compensate physicians for foregoing work in a non-hospital setting where reimbursement may be higher and uncompensated care losses lower. Payments for on-call and standby are highly dependent on local market factors. A shortage of certain specialties, as occurs in many more rural areas, may drive payments higher and an ample supply of physicians may eliminate the need to offer payments. The need to ensure physician availability is especially

[6]A physician on call is available and able to reach the hospital within 30 minutes of notification. When on standby, the physician is at the hospital ready to respond.

acute in trauma care. Most trauma center hospitals reimburse physicians when they provide on-call and certainly when physicians are on standby at the hospital. Level III trauma centers must maintain 30 minute maximum response times for trauma surgeons, anesthesiologists, neurosurgeons, and orthopedists. Level II centers must have a trauma surgeon and an anesthesiologist on standby and a neurosurgeon and orthopedist on on-call and able to respond within 30 minutes. An anesthesiologist and a trauma surgeon must be on standby at a Level II center.[7]

On-call expenses in calendar year 2006 were reimbursed for the number of on-call hours provided up to a maximum of 8,640 hours per specialty service. None of the centers reached the maximum payment ceilings allowable under the Fund. The centers did not reach the on-call ceilings because some specialties operated on standby, a higher level of availability. Some physician contracts also allow for on-call payments only when the physician is on-call and not providing care. If physician is called to the hospital and hence generating billable services, the hospital does not reimburse for on-call. Other trauma hospitals maintained trauma specialists on-call without paying on-call stipends.

Table 5 -- Trauma Fund On-Call Payments To Level II and Level III Trauma Centers

Trauma Facility	FY 2005	FY 2006
	Total Paid	Total Paid
Level II		
Johns Hopkins Bayview Medical Center*	$ 202,320	$459,093
Prince George's Hospital Center	109,200	358,118
Sinai Hospital of Baltimore	264,120	445,922
Suburban Hospital	258,164	327,119
Level III		
Peninsula Regional Medical Center	561,262	919,742
Washington County Hospital Association	584,245	789,501
Western Maryland Health System	321,026	$448,569
TOTAL	$ 2,300,338	$3,748,065

The on-call payments are based on on-call costs reported by the trauma centers for the period from January 2005 through December 2005.

[7] Level II trauma centers may substitute a third year surgical resident for a trauma surgeon, the trauma surgeon then must be on call.

HSCRC Standby Expense Allocation

HSCRC included standby costs incurred in having a trauma surgeon, orthopedic surgeon, neurosurgeon, and anesthesiologist in the trauma center, in the FY 2006 reimbursement rates for hospitals with trauma centers. The total amount included in hospital rates for FY 2006 was approximately $4.3 million, which was based on hospital standby expenses reported to HSCRC in FY 2003 inflated forward by the cumulative update factor. Table 6 represents the amount that each hospital received effective July 1, 2005 for standby costs incurred by the trauma center. The Commission used the Reasonable Cost Equivalent (RCE) methodology employed by Medicare in determining reasonable allowable standby costs. The amounts shown in Table 6 are part of the general rate base of each hospital through the end of FY 2006.

HSCRC continues to collect standby cost data from hospitals with trauma centers on an annual basis. If a hospital wishes to increase standby expenses in rates and qualifies under HSCRC rules and procedures, a full rate review would be required. HSCRC would utilize the annual standby cost data collected from all trauma centers in its full rate review analysis.

Standby allocation costs do not have any impact on the Fund because the expenses are incorporated into the approved rates that hospitals are allowed to charge third party payers.

Table 6- Maryland Trauma Standby Costs in HSCRC-Approved Rates FY 2006

	Inpatient	Outpatient	Total $
Johns Hopkins Hospital	$ 639,172	$ 96,304	$ 735,477
Prince George's Hospital Center	1,228,078	35,039	1,263,117
Sinai Hospital	490,995	406,006	897,001
Suburban Hospital	345,908	161,228	507,136
Peninsula Regional Medical Center	-	-	-
Washington County Hospital	399,943	195,109	595,051
Western Maryland Health System	239,216	48,874	288,090
Total	$ 3,374,631	$ 946,315	$ 4,320,946

Note: Peninsula Regional Medical Center reports no standby costs. Approximately $4,127,800 in standby expense was included in FY 2005; the difference in FY 2006 is solely due to HSCRC annual updates for inpatient and outpatient services.

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. Children's reported approximately $1.2 million in comparable standby expenses for which it received the maximum allowable stipend of $275,000 in 2005 (paid in FY 2006).

The treatment of standby at Children's is of note because of the nature of this hospital. Trauma physicians serving the trauma center at Children's are salaried to the Children's National Medical Center. After an initial review, MHCC permits the trauma center to make assumptions on the share of salary for each specialty that is associated with standby or so called availability time. Using these assumptions, Children's reports equivalent standby spending well in excess of the maximum stipend allowed. MHCC will review these assumptions in FY 2007 when the standby stipend will increase to $490,000.

Audit Expenses

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 January 1, 2005 through June 30, 2005 and the 6-month reporting cycle from July 1, 2005 through December 31, 2005. During that period, the auditor identified $120,000 in recoveries for the Trauma Fund. Approximately $95,000 in recoveries was for uncompensated care in which the practice did not document attempts to collect from the patient or did not bill a health insurance carrier, when one was responsible. MHCC has found that many trauma physicians do not understand that they are eligible for reimbursement from an HMO even when they do not participate in that HMO's network. In these cases, uncompensated care payments are recovered and the practice is educated on how to bill the HMO. The remaining $25,000 in recoveries was for on-call payments to hospitals.

Outlook for Future Revenue and Disbursements

The Maryland General Assembly passed HB 1164 (Maryland Trauma Physician Services Fund - Reimbursement Rates – Grants) on the final day of the 2006 Session of the Maryland General Assembly. The key provisions are as follows:

- The number of trauma physician specialties eligible to receive uncompensated care and Medicaid payments from 5 specialties to approximately 26 specialties.
- The formula for trauma on-call grants increases by 50 percent for Level II Trauma Centers and by 17 percent for Level III Trauma Centers.
- Three specialty trauma centers become eligible for uncompensated care and Medicaid under-payment reimbursement::
    - The Regional Burn Center at Johns Hopkins Bayview Medical Center;
    - The Eye Trauma Center at the Wilmer Eye Institute at Johns Hopkins Hospital
    - Curtis National Hand Center at Union Memorial Hospital
- The grant to the Children's National Medical Center for standby services increases to $490,000 from $275,000 under the former law.
- $3 million was set aside from the Trauma Fund surplus at the end of FY 2006 for grants to Level I and Level III trauma centers for equipment used primarily for trauma care. Before awarding grants, the MHCC is directed to report to the Senate Finance Committee and the House Health and Government Operations Committee on the process for awarding grants.
- A one-time grant for standby expenses of $300,000 was given to the Curtis Hand Center at Union Memorial Hospital.

Regulatory Changes

The MHCC adopted emergency and proposed regulations (COMAR 10.25.10) that implemented the changes in Trauma Fund eligibility required by HB 1164. The new regulations made any physician that treated an uninsured trauma patient in a hospital setting eligible for uncompensated care. The Medicaid Administration made equivalent changes in Medicaid rules to expand eligibility for elevated payments. The regulations also permit follow-up trauma care directly related to the initial injury to be reimbursed by the Fund.

The regulations increased funding levels for on-call payments as required by the statute. Regulations modified the rules for on-call payments to allow Level II and Level III trauma centers more flexibility in using on-call funds by removing the maximum allowable payments for individual specialties. The overall ceiling for on-call payments by centers remain. These changes will be especially helpful for regional trauma centers that must compete for scarce trauma specialists in orthopedics, neurosurgery, and trauma surgery.

The Administrative Executive and Legislative Review Committee reviewed and released the proposed regulations. The emergency regulations were reviewed and released on September 20, 2006. The proposed regulations were adopted as final regulations on September 21, 2006 and become effective in December of 2006.

Contracting for a Third Party Administrator (TPA)

HB 1164 expanded the number of specialties eligible for the Fund. Staff estimates that the number of eligible practices will likely double. As the current ad hoc application is difficult for practices to complete, staff concluded that it would be most efficient to establish a more standard claim adjudication process for paying uncompensated care. This process would include most elements of claim adjudication with which practices are already familiar. As the MHCC and HSCRC do not have in-house capabilities to adjudicate claims, an outside contractor is needed. The MHCC completed an RFP to identify an administrator that can process claims from physician practices that provide uncompensated trauma services. The RFP was released on October 3, 2006. MHCC expects to make a contract award in early November. The TPA selected should be able to accept claims in early January.

Trauma Grant Program

The Maryland Health Care Commission (MHCC), in consultation with the Maryland Institute for Emergency Medical Services Systems (MIEMSS) and the Health Services Cost Review Commission (HSCRC) developed a one-time equipment grant program for the seven Level II and Level III trauma centers. MHCC has developed a grant program that is equitable and streamlined for all trauma centers, but ensures appropriate oversight of the grant. Under the proposed grant program, each center will be eligible for up to $425,000 for equipment used in trauma care. Dividing the funds equally among the seven centers is prudent, because all centers have significant capital needs associated with their trauma programs. A capital equipment survey conducted by MIEMSS in 2004 found that the seven trauma centers had unmet capital needs totaling $16 million. The draft grant application, which is enclosed with this letter, requires the centers simply to document intended equipment purchases and to report the percent of time that the equipment will be used in trauma care. Funds will be disbursed once a grant application is reviewed and approved by a panel composed of a representative from each of the three state agencies. The centers will be required to document purchases and to complete all purchases by the end of the hospital's 2008 fiscal year. Grant funds not spent by the end of FY 2008 must be returned. MHCC retained Clifton-Gunderson, LLP to conduct audits of the centers to confirm that the requirements of HB 1164 and the grant process will be met.

The MHCC held an informational meeting with the seven Level II and Level III trauma centers on September 19th. The centers reviewed the application and agreed that the information MHCC requested was reasonable. At the request of several centers, MHCC decided to allow equipment held through capital leases to be considered for grant funding. MHCC will consider equipment leases as equivalent to the purchases if they are a direct substitute for the purchase of the asset (equipment) and it transfers all risks and benefits associated with ownership to the hospital.[8]

[8] As a general rule for accounting purposes, a lease can be treated as a capital expenditure, (an asset) when it meets any one of the following tests: (1) Title transfers to the hospital at the end of the lease term; (2) The lease has a bargain purchase element at the end of the lease term; (3) The lease term exceeds 75% of the useful economic life of the asset; and, (4) The present value of the minimum lease payments exceeds 90% of the fair market value (FMV) of the asset at lease inception.

The centers asked that MHCC release the applications as soon as possible so that grant money could be released for FY 2007 equipment purchases. The MHCC reported to the Senate Finance and House Health and Government Operations Committees on the grant program as required under HB 1164.

Revenue and Spending Outlook

Table 7 presents estimated collections from the motor vehicle surcharge and estimated disbursements under existing and the expanded eligibility criteria from FY 2007 through 2009.

Table 7 Trauma Fund Spending 2007-2009

(Preliminary)

	FY 2007	FY 2008	FY 2009
Carryover Balance from Previous Fiscal Year	**$20,794,637**	**$20,026,541**	**$20,044,754**
Collections from the $5. surcharge on automobile renewals	**12,834,000**	**13,116,000**	**13,404,196**
TOTAL BALANCE and COLLECTIONS	**33,628,637**	**33,142,541**	**33,448,950**
Payments to Trauma Physicians			
Uncompensated Care	**-4,080,000**	**-5,100,000**	**-5,500,000**
Medicaid Under-payments	**-400,000**	**-650,000**	**-500,000**
Payments to Trauma Centers			
On-call Payments to Level II and Level III Trauma Centers	**-5,622,096**	**-6,652,787**	**-6,785,843**
Standby Payment to Children's National Medical Center		**-490,000**	**-490,000**
Trauma Equipment Grants to Level II and Level III Centers	**-3,000,000**	[redacted]	[redacted]
Standby Grant to the Curtis Hand Center at Union Memorial	**-300,000**	[redacted]	[redacted]
MHCC Administrative Expenses (TPA & Audit)	**-200,000**	**-205,000**	**-210,000**
TOTAL DISBURSEMENTS	**-13,602,096**	**-13,097,787**	**-13,485,843**
YEAR END BALANCE	**20,026,541**	**20,044,754**	**19,963,108**

Note: Fiscal year end balances do not include obligations incurred, but not paid

MHCC does not believe further changes in the distribution formula or eligibility criteria for the Trauma Fund are warranted in 2007. Although all the provisions HB 1164 are in the process of being implemented, it will take time for the centers and the specialties to fully understand the implications of the changes. For example, the three specialty referral centers (Curtis Hand Center, Eye Trauma Center at the Wilmer Institute, and the JHU Burn Center at Bayview) do not currently submit the same type of trauma registry information to MIEMSS. New registry requirements must be developed for these specialty centers before specialists serving patients at those centers can submit claims for uncompensated or Medicaid elevated payments. Many of the specialties that are eligible for uncompensated care and Medicaid elevated payment may not be aware of changes in law and they may not be able to immediately respond to the submission requirements for the program. MHCC believes that at least one additional year is needed to fully implement the changes enacted through HB 1164 before the General Assembly should consider modifications to the Fund.

Some uncertainty exists regarding the impact of reimbursing follow-up trauma care after the initial hospitalization. During the rulemaking process, a number of specialties pointed out that they provided substantial care after the initial trauma hospitalization. Plastic surgery, ophthalmic, oral, maxillofacial, and orthopedic surgery often occur after the initial hospital visit. Burn care treatment, in particular, can extend for a considerable time after the initial injury. In recognition of these concerns and to ensure that care is provided in the most cost-effectively manner, subsequent follow-up care is reimbursed by the Trauma Fund if the treatment is directly related to the initial injury. The MHCC, as administrator, will have final determination of what is directly related to the initial trauma.

MHCC believes further input will likely be needed from providers of trauma care and specialty societies on the span of time needed to treat trauma injuries. MHCC and MIEMSS will convene physician panels to provide guidance on specific time limits for follow-up care by broad categories of trauma injury.

Appendices

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

Prior Year Revenue	$	22,097,012
Jul-05		945,001
Aug-05		1,161,480
Sep-05		1,025,548
Oct-05		1,086,710.26
Nov-05		920,438
Dec-05		869,537
Jan-06		951,522
Feb-06		859,078
Mar-06		1,116,470
Apr-06		1,143,870
May-06		1,116,013
Jun-06		1,251,778
Subtotal—YTD	$	12,553,359
Totaled Collected Since Fund Inception	$	34,544,456

Note: Monthly totals include interest earned during the month.

Appendix Table 2 --Maryland Trauma Physician Services Fund

Uncompensated Care Payments Made in FY2006

(listed in alphabetical order)

TRAUMA PHYSICIAN/GROUP	FY2005
Andre Gazdag, M.D./BCCOA	$ 3,849.40
Associated Anesthesiology Practice, PA	17,374.51
Bethesda Emergency Associates, LLC (ED)	11,235.04
Betsy Ballard, M.D.	13,939.41
Bijan Bahmanyar, M.D.	157,640.88
Blue Ridge Anesthesia Associates, LLC	9,498.57
Boyd E. Sprenkle, M.D.	2,819.64
Brajendra Misra, M.D.	52,880.57
Center for Joint Surgery and Sports Medicine	2,719.44
Cumberland Anesthesia & Pain Management Assoc, PC	1,322.91
Cumberland Emergency Medical Group, PA (ED)	3,831.08
Drs. Falik & Karim, PA	42,667.98
Emergency Services Associates, PA (ED)	93,860.44
Enrique Daza, M.D.	55,651.15
Ernest Hanowell, M.D.	43,621.02
First Colonies Anesthesia Associates	44,956.48
Harvey C. Shapiro, M.D.	43,950.33
James W. Robey, M.D.	26,227.43
Johns Hopkins Bayview Medical Center	126,344.22
Johns Hopkins Bayview Medical Center (ED)	53,527.91
Johns Hopkins Adult Trauma Center	421,822.16
Johns Hopkins Adult Trauma Center (ED)	127,787.50
Johns Hopkins Pediatric Trauma Center	31,058.45
Johns Hopkins Pediatric Trauma Center (ED)	30,291.64
Mark A. Sagin, M.D.	2,219.65
Memorial Hospital Orthopedic Group	1,290.25
Mid Atlantic Orthopaedic Spec.	16,995.48
Mohammad Ali Khan, M.D.	53,695.51
Montague Blundon, III, M.D.	62,465.08
North American Partners in Anesthesia-MD	22,065.40
Olumuyiwa Paul, M.D.	3,981.01
Peninsula Neurosurgical Associates	15,304.97
Peninsula Orthopaedic Associates, PA	8,641.74

Peninsula Pulmonary Associates , PA	7,775.27
PGHC Anesthesia Associates	18,470.03
PGHC Critical Care Center	67,996.97
PGHC Trauma Associates	45,428.71
Ramin M. Jebraili, M.D.	25,029.33
Ricardo Pyfrom, M.D.	13,997.76
Sagar V. Nootheti, M.D.	35,099.72
Said A. Daee, M.D.	78,464.80
Sinai Faculty Practice Plan	92,761.05
Sylvanus Oyogoa, M.D.	45,498.67
Trauma Services (Cumberland)	1,310.17
Trauma Surgery Associates, LLC (Bethesda)	41,057.33
Trauma Surgical Associates (Salisbury)	49,447.15
University Physicians, Inc.	492,260.21
Vincent O. Casibang, M.D.	31,365.47
Washington Brain & Spine Institute	4,374.04
Washington County Emergency Medicine Physicians (ED)	37,539.35
Washington County Hospital Trauma Physicians	45,554.40
Western Maryland Trauma Associates, PA	7,358.83
Willie C. Blair, M.D.	79,649.70
Yardmore Emergency Physicians (ED)	23,580.81
Application Total	$ 2,849,557.03
Prior Period Recovery Adjustments	203,237.55
Disbursement Amount	$ 2,646,319.48

Appendix Table 3 --Maryland Trauma Physician Services Fund

Uncompensated Care Payments Made in FY2006

(listed by dollar amount)

TRAUMA PHYSICIAN/GROUP	FY2005
University Physicians, Inc.	$ 492,260.21
Johns Hopkins Hospital Adult Trauma Center	421,822.16
Bijan Bahmanyar, M.D.	157,640.88
Johns Hopkins Hospital Adult Trauma Center (ED)	127,787.50
Johns Hopkins Bayview Medical Center	126,344.22
Emergency Service Associates	93,860.44
Sinai Faculty Practice Plan	92,761.05
Willie C. Blair, M.D.	69,291.73
PGHC Critical Care Center	67,996.97
Said A. Daee, M.D.	65,282.55
Montague Blundon, III, M.D.	62,465.08
Enrique Daza, MD	55,651.15
Mohammad Ali Khan, M.D.	53,695.51
Johns Hopkins Bayview Medical Center (ED)	53,527.91
Trauma Surgical Associates	49,447.15
Washington County Hospital Trauma Physicians	45,554.40
Sylvanus Oyogoa, M.D.	45,498.67
PGHC Trauma Associates	45,428.71
First Colonies Anesthesia Associates	44,956.48
Harvey C. Shapiro, M.D.	43,950.33
Ernest Hanowell, M.D., PC	43,621.02
Drs. Falik & Karim P.A.	42,667.98
Brajendra N. Misra, M.D.	42,538.29
Trauma Surgery Associates, LLC	41,057.33
Washington County Hospital (ED)	37,539.35
Sagar V. Nootheti, M.D., PA	35,099.72
Vincent O. Casibang, M.D.	31,365.47
Johns Hopkins Hospital Pediatric Trauma Center	31,058.45
Johns Hopkins Hospital Pediatric Trauma Center(ED)	30,291.64
James W. Robey, M.D.	26,227.43
Ramin M. Jebraili, M.D.	25,029.33
Yardmore Emergency Physicians (ED)	23,580.81
North American Partners in Anesthesia-MD	22,065.40

PGHC Anesthesia Associates	18,470.03
Associated Anesthesiology Practice, PA	17,374.51
Mid Atlantic Orthopaedic Spec.	16,995.48
Peninsula Neurosurgical Associates	15,304.97
Ricardo Pyfrom, M.D.	13,997.76
Betsy Ballard, M.D.	13,939.41
Said A. Daee, M.D.	13,182.25
Bethesda Emergency Associates, LLC (ED)	11,235.04
Willie C. Blair, M.D.	10,357.97
Brajendra N. Misra, M.D.	10,342.28
Blue Ridge Anesthesia Associates, LLC	9,498.57
Peninsula Orthopaedic Associates PA	8,641.74
Peninsula Pulmonary Assoc., PA	7,775.27
Western Maryland Trauma Associates, PA	7,358.83
Washington Brain & Spine Institute	4,374.04
Olumuyiwa Paul, M.D.	3,981.01
Andre Gazdag, M.D./BCCOA	3,849.40
Cumberland Emergency Medical Group, PA (ED)	3,831.08
Boyd E. Sprenkle, M.D.	2,819.64
Center for Joint Surgery and Sports Medicine	2,719.44
Mark A. Sagin, M.D.	2,219.65
Application Total	$ 2,849,557.03
Prior Period Recovery Adjustments	203,237.55
Disbursement Amount	$ 2,646,319.48

Appendix Table 4 – On Call Maximum Payments for CY 2005

Maximums for On Call Payments based on CMS Reasonable Compensation Equivalents as of August 1, 2005			
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			$178,879
Orthopedic Surgery			$178,879
Trauma Surgery (for Sinai, Suburban, and Johns Hopkins Bayview only)			$178,879
Level III Trauma Centers			
Anesthesiology	$216,074	$258,386	
Neurosurgery	$235,940	$263,288	
Orthopedic Surgery	$235,940	$263,288	
Trauma Surgery	$235,940	$263,288	
TOTAL	$923,894	$1,048,249	$536,638

Note: *Based on CMS Reasonable Compensation Equivalents as of August 1, 2003 using inflation factor of 2.1%

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 5 --Maryland Trauma Physician Services Fund

On Call Payments Made in FY2006

Trauma Facility	Anesthesia	Neurosurgery	Orthopedic Surgery	Trauma Surgery	Payment Adjustments	On Call Total
	FY2006	FY2006	FY2006	FY2006	FY2006	FY2006
Johns Hopkins Bayview Medical Center	$0.00	$177,055.00	$177,055.00	$116,394.00	($11,411.00)	$459,093.00
Peninsula Regional Medical Center	$216,074.00	$233,940.00	$233,938.00	$235,940.00	($149.33)	$919,742.67
Prince George's Hospital Center	$0.00	$178,879.00	$178,879.00	$0.00	$360.14	$358,118.14
Sinai Hospital of Baltimore	$0.00	$178,879.00	$178,879.00	$95,587.00	($7,422.85)	$445,922.15
Suburban Hospital	$0.00	$73,022.00	$171,528.00	$80,649.00	$1,920.05	$327,119.05
Washington County Hospital Association	$0.00	$263,288.00	$263,288.00	$263,277.00	($351.72)	$789,501.28
Western Maryland Health System	$0.00	$230,995.00	$28,923.00	$206,271.00	($17,619.88)	$448,569.12
TOTAL	$216,074.00	$1,336,058.00	$1,232,490.00	$998,118.00	($34,674.59)	$3,748,065.41

APPENDIX 6 – TRAUMA EQUIPMENT GRANT APPLICATION

DRAFT

Maryland Health Care Commission

Maryland Trauma Fund
Equipment Grant Application

Request for Funding

Stephen J. Salamon
Chairman

Rex W. Cowdry, M.D.
Executive Director

Revised September 1, 2006

Maryland Trauma Fund
Equipment Grant Application

Table of Contents

DRAFT

Maryland Trauma Fund
Equipment Grant Application

Background on the Trauma Grant Program

A capital equipment need survey completed by the Maryland Institute for Emergency Medical Services Systems (MIEMSS) identified about $12 million in system wide unmet trauma equipment needs for the period from 2005-2007. Recognizing that the needs of regional trauma center hospitals were especially great, legislators in 2006 allocated $3 million dollars from the Maryland Trauma Physician Services Fund (Fund) surplus to finance the purchase of equipment used in the treatment of trauma patients.

The $3 million dollars in total funding will be apportioned equally among the eligible trauma centers. All Level II and Level III trauma centers are eligible for up to $425,000 in equipment funding. All equipment funded through this program must be purchased in the hospital's 2007 or 2008 fiscal years.

Application Process

A trauma center hospital must complete this application to be eligible for a Trauma Grant. Please take special care in completing the *Unfunded Trauma Equipment Inventory* (Table 1). Complete each cell for all equipment that you wish the State to consider under the Grant. Provide an estimate of the purchase price and the percentage that the equipment is used for the trauma program. Please document how the equipment price was obtained and the method used to determine the amount of trauma program use. Trauma center hospitals may wish to refer to COMAR 30.08.05.13 to determine the equipment that hospitals are required to operate for MIEMSS designation as a Level II or Level III trauma center (see Attachment 1). Hospitals should list only equipment that has a purchase value in current (2006 dollars) of $5,000 or more. **Please submit your Equipment Grant Application to MHCC by ????? 1, 2006.**

Review Process

MHCC, MIEMSS, and the Health Services Cost Review Commission (HSCRC) will evaluate the Equipment Grant Applications. The reviewers will give priority to funding equipment using the following factors:

(1) Equipment required under COMAR 30.08.05.13 for hospitals designated by MIEMSS as a Level II or Level III trauma center. (see Attachment 1)
(2) Equipment used primarily in the trauma program (50% or more), but not specifically designated under COMAR regulations.
(3) Other equipment not designated in COMAR, but used at least 10 percent of the time for trauma care.

Hospitals will receive grants based on the estimated use of equipment for trauma care. For example, if a CT scanner costs $1,000,000 and used 25 percent of the time for trauma patients (based on the hospital's estimation method), then the trauma center would be eligible for a

$250,000 equipment grant. If the estimated equipment purchase price or trauma use level differ from industry standards available to the State, MHCC may ask the hospital to submit additional documentation to support this variance. The State anticipates making awards by December 15, 2006. Funds will be released to the hospitals at the time of award. The maximum total funding available to any hospital is $425,000.

Documentation Requirements

A hospital must provide documentation that the equipment was purchased in the year specified. A purchase order or contract binding the hospital will represent suitable documentation that the equipment has been purchased. Documentation must be submitted to MHCC within 60 days of the hospital's fiscal year end in which the equipment was purchased. The Commission reserves the right to audit hospitals for equipment purchased under this Program. Audits will be conducted by Clifton Gunderson, LLC, the Trauma Fund auditor or another representative designated by MHCC. The Commission may ask that the hospital document the amount of time the equipment is used for trauma care.

Limitations

A hospital that has not spent funds awarded under the Trauma Equipment Grant Program by the close of its 2008 fiscal year must return these funds to the Trauma Fund. A hospital may not reprogram Grant money to other capital equipment or any other purpose without prior written permission from MHCC.

Maryland Trauma Fund
Equipment Grant Application

BEFORE YOU MAIL CHECK LIST

(1) Did you review this application to verify that all of the information provided is accurate?

(2) Did you provide a response to each of the questions on every page?

(3) Did you report all proposed trauma equipment to be purchased in FY 2008 or FY 2009 on page 7?

(4) Did the Chief Financial Officer sign the statement of verification on page 8?

DRAFT

Application Questions

PLEASE BEGIN REPORT

1. The information reported in this application is for expected equipment purchased in the applicant's FY 2008 and FY 2009. Please identify the time period represented in this report.

Beginning			
	Mo.	Day	Yr.
Ending			
	Mo.	Day	Yr.

2. Trauma Center Name _____

   Street _____

   City/State _____

   Zip Code _____ Area Code/Telephone _____

   E-mail Address _____

3. Please list the person to contact for information concerning this report:

   Name _____

   Title _____

   Area Code/Telephone _____

   E-mail Address _____

4. What is your trauma center's designation level? (select one response)

   Level II Trauma Center

   Level III Trauma Center

5. Please provide responses in Table 1 for the list of equipment, area of use, anticipated year of purchase, estimated equipment cost, percentage of equipment use in the trauma program, source of equipment cost estimate, and the method used to determine the equipment use for the trauma program.

Table 1: Unfunded Trauma Equipment Inventory

<u>Part 1. Equipment Category</u> --- Identify where Equipment is used: Emergency Dept. (ED); Resuscitation (R); Operating Room (OR); Critical Care (CC); Radiology (RAD)*

Equipment LIst	*Indicate Area of Use (ED, R, OR, CC, RAD)	Anticipated Year of Purchase	Estimated Equipment Cost (Based on Current Cost Analysis)	% Equipment Used Specifically For Trauma Program	Source of Equipment Cost Estimate	Method Used to Determine Equipment Use For Trauma Program

Maryland Trauma Fund
Equipment Grant Application

VERIFICATION OF INFORMATION

I hereby certify that the facts stated in the Maryland Trauma Fund Equipment Grant Application are correct to the best of my knowledge. I am the Chief Financial Officer of the Hospital, and can verify that all information submitted in this form is accurate and true.

(Name of Trauma Center/Hospital - please print or type)

(Chief Financial Officer – please print or type)

(Chief Financial Officer - Signature)

(Date)

Glossary of Terms

Application – The Maryland Trauma Fund Equipment Grant Application.

Commission or MHCC – Maryland Health Care Commission.

Fraud – The act of (1) knowingly and willfully making or causing any false statement or representation of a material fact in any application for payment and (2) knowingly and willfully making or causing any false statement or representation of a material fact for use in determining rights to payments.

Fiscal Year – A 12-month accounting period that may or may not end on December 31st.

Fund – Maryland Trauma Physician Services Fund.

HSCRC – Health Services Cost Review Commission.

MIEMSS – Maryland Institute for Emergency Medical Services Systems.

Report – Information required by the Maryland Health Care Commission for the purpose of distributing funds.

Trauma Center – A facility designated by the Maryland Institute for Emergency Medical Services Systems as:

1. The State Primary Adult Resource Center
2. A Level I Trauma Center
3. A Level II Trauma Center
4. A Level III Trauma Center
5. A Pediatric Trauma Center
6. Trauma Center includes an out-of-state Pediatric Trauma Center that has entered into an agreement with the Maryland Institute for Emergency Medical Services Systems.

.13 Facility or Unit Capabilities.

	PARC	*I*	*II*	*III*	*ED*
A. Emergency Department. Emergency department requirements are as follows:					
(1) A designated physician director and nurse manager;	NA	E	E	E	E
(2) Board-certified or board-eligible attending physician with demonstrated competence in the care of critically injured patients in-house 24 hours a day;	NA	E	E	E	D
(3) Dedicated trauma resuscitation unit with dedicated staff, equipment, and supplies 24 hours a day;	E	D	NA	NA	NA
(4) Senior attending trauma surgeon available 24 hours a day through SYSCOM as a resource for trauma consultation Statewide;	E	NA	NA	NA	NA
(5) A sufficient number of registered nurses and other providers, who are competent to provide care during trauma resuscitation and present in sufficient numbers to manage projected case load, and a plan to reinforce the number of staff on immediate notice of multiple admissions;	E	E	E	E	E
(6) Equipment and supplies organized for trauma resuscitation present and immediately available 24 hours a day;	E	E	E	E	E
(7) Identified trauma cubicle or room for trauma resuscitation;	NA	E	E	E	E
(8) Direct communication link to prehospital providers and transport vehicles;	E	E	E	E	E
(9) Designated as base station by MIEMSS;	E	E	E	E	NA
(10) Sterile surgical sets located in the ED for:	E	E	E	E	E
(a) Airway control or cricothyrotomy,					
(b) Thoracotomy,					
(c) Vascular access,					
(d) Chest decompression, and					
(e) Peritoneal lavage;					
(11) Policies and protocols for trauma team response and roles in ED trauma resuscitation in accordance with Regulation .03G of this chapter;	E	E	E	E	E
(12) Drugs necessary for emergency care;	E	E	E	E	E
(13) Autotransfusion equipment and capability immediately available.	E	E	E	E	E
B. Operating Room. Operating room requirements are as follows:					
(1) Operating room or rooms adequately staffed with in-house personnel dedicated to trauma 24 hours a day;	E	D	NA	NA	NA
(2) Operating room available within 15 minutes of notification with adequate in-house staff;	NA	E	E	E	NA
(3) X-ray capability including C-arm image intensifier 24 hours a day;	E	E	E	E	NA
(4) Equipment and instrumentation appropriate for:					
(a) Neurosurgery,	E	E	E	E	NA
(b) Vascular surgery,	E	E	E	E	NA
(c) Pelvic and long-bone fracture fixation, and	E	E	E	E	NA
(d) Cardiopulmonary bypass;	E	E	D	NA	NA
(5) Blood recapturing and warming equipment;	E	E	E	E	NA
(6) Endoscopes.	E	E	E	E	NA
C. Post-Anesthesia Recovery Room. Post-anesthesia recovery room requirements are as follows:					
(1) Dedicated to trauma and staffed 24 hours a day;	E	NA	NA	NA	NA
(2) Room available to trauma patients with registered nurses and other essential staff 24 hours a day;	NA	E	E	E	NA
(3) Equipment for continuous monitoring of temperature, hemodynamics, and gas exchange.	E	E	E	E	NA
D. Intensive Care Unit. Intensive care unit requirements are as follows:					
(1) Dedicated intensive care unit for trauma with appropriately trained registered nurse staff;	E	NA	NA	NA	NA

(2) Priority bed availability for trauma patients with appropriately trained registered nurses in sufficient numbers based on patient acuity;	NA	E	E	E	NA
(3) Written plan for triaging patients from the intensive care unit to free up beds for trauma patients when necessary or provision of alternate critical care beds for trauma patients with appropriately trained registered nurse staff;	E	E	E	E	NA
(4) Equipment for monitoring and resuscitation;	E	E	E	E	D
(5) Support services with immediate access to clinical diagnostic services such as arterial blood gases, hematocrits, and chest X-rays available within 30 minutes;	E	E	E	E	NA
(6) Acute continuous hemodialysis capability.	E	E	E	E	NA
E. Acute Spinal Cord or Head Injury Management Capability. Acute spinal cord or head injury management requirements are as follows:					
(1) Dedicated neurotrauma units with dedicated, specialty trained nursing and support staff;	E	NA	NA	NA	NA
(2) Neuro-intensive care unit with intracranial pressure capabilities for trauma patients;	NA	E	NA	NA	NA
(3) Transfer agreements with designated spinal or head injury trauma centers and spinal or head injury rehabilitation centers.	NA	E	E	E	NA
F. Burn Care. Burn care requirements are as follows:					
(1) Adult or pediatric burn center:	E	E	E	E	E
(a) Designated by MIEMSS and approved by the EMS Board under this subtitle,					
(b) Staffed by nursing personnel trained in burn care, and					
(c) Properly equipped for the care of extensively burned patients; or					
(2) Transfer agreements with a designated adult or pediatric burn center.	E	E	E	E	E
G. Radiological Special Capabilities. Radiological special capabilities requirements are as follows:					
(1) In-house trauma-dedicated technicians 24 hours a day;	E	NA	NA	NA	NA
(2) In-house radiology technicians 24 hours a day;	E	E	E	E	NA
(3) Dedicated computed tomography (CT) scan and angiography facilities and staff 24 hours a day;	E	NA	NA	NA	NA
(4) Angiography;	E	E	E	E	NA
(5) Sonography;	E	E	E	E	D
(6) Nuclear scanning;	E	E	E	E	NA
(7) Magnetic resonance imaging;	E	E	E	D	D
(8) Computed tomography (CT):					
(a) Computed tomography (CT) in-house and available 24 hours a day,	E	E	E	E	NA
(b) In-house CT technician 24 hours a day,	E	E	E	NA	NA
(c) CT technician on-call and available within 30 minutes, and	NA	NA	NA	E	NA
(d) Back-up CT scan capabilities.	E	E	E	E	NA
H. Rehabilitation. Rehabilitation requirements are as follows:					
(1) Rehabilitation services staffed by personnel trained in rehabilitative care and properly equipped for acute care of the critically injured patient;	E	E	D	D	NA
(2) Full in-house service or transfer agreement to a rehabilitation service for long-term care;	NA	E	E	E	NA
(3) Ongoing continuity of care for patients with traumatic brain, musculoskeletal, and soft tissue injuries provided in an affiliated rehabilitation facility by attending trauma center specialists and subspecialists.	E	NA	NA	NA	NA
I. Clinical Laboratory Service.					
(1) A clinical laboratory service shall be available 24 hours a day capable of providing:	E	E	E	E	E
(a) Standard analysis of blood, urine, and other body fluids;					
(b) Blood-typing and cross-matching;					
(c) Comprehensive blood bank or access to a central blood bank in the community and adequate storage facilities with stock minimums set by protocol for blood products;					
(d) Blood gases and pH determinations;					

(e) Coagulation studies;					
(f) Microbiology; and					
(g) Drug and alcohol screening.					
(2) A dedicated satellite lab facility shall be available near or in the trauma resuscitation area for essential lab studies.	E	E	NA	NA	NA
J. Equipment for Resuscitation. Equipment for resuscitation of patients of all ages in the emergency department, operating room, post-anesthesia care unit, or intensive care unit shall include:					
(1) Immediately available equipment such as:	E	E	E	E	E
(a) Airway control and ventilation equipment, including laryngoscopes and endotracheal tubes of all sizes, bag-mask resuscitator, pocket masks, and oxygen,					
(b) Suction devices,					
(c) Pulse oximetry,					
(d) Electrocardiograph-oscilloscope-defibrillator, and					
(e) Standard intravenous fluids and administration devices, including large-bore intravenous catheters; and					
(2) Readily available equipment such as:					
(a) End-tidal CO_2 determination,	E	E	E	E	E
(b) Apparatus to establish hemodynamic monitoring,	E	E	E	E	NA
(c) Skeletal traction devices, including capability for cervical traction,	E	E	E	E	E
(d) Arterial catheters,	E	E	E	E	NA
(e) Thermal control equipment for patient and fluids, and	E	E	E	E	E
(f) Compartmental pressure measuring device.	E	E	E	E	D

MARYLAND TRAUMA FUND
EQUIPMENT GRANT APPLICATION

PLEASE REVIEW THE CHECK LIST
AT THE BEGINNING OF THE APPLICATION.

PLEASE RETURN APPLICATION TO:

Ben Steffen, Director
Center for Information Services & Analysis
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore MD 21215

trauma@mhcc.state.md.us
410-764-3570
410-358-1236 (FAX)