MARYLAND TRAUMA PHYSICIAN SERVICES FUND

Health General Article § 19-130

Operations from July 1, 2006 through June 30, 2007

Report to the

MARYLAND GENERAL ASSEMBLY

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This annual report on the Maryland Trauma Physicians Services Fund for fiscal year 2007 meets the reporting requirement under 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.

Executive Summary

The Maryland Trauma Physician Services Fund ("Trauma Fund" or "Fund") covers the costs of medical care provided by trauma physicians at Maryland's designated trauma centers for uncompensated care patients, Medicaid enrolled patients, and trauma related on-call expenses. The Fund is financed through a $5 surcharge on motor vehicle registrations and renewals. A balance of about $20 million developed in the Trauma Fund as collections exceeded spending in the first four years of operation. House Bill 1164 (Trauma Reimbursement and Grants) passed during the 2006 session of the Maryland General Assembly realigned spending with collections by increasing the physicians specialties eligible for uncompensated and Medicaid under-compensated care and raised the on-call reimbursement formula for trauma centers. Trauma physicians at three specialty referral centers became eligible for uncompensated care reimbursement and elevated Medicaid payments. The General Assembly directed the MHCC to award trauma equipment grants totaling $3 million from the balance in the Trauma Fund at the end of FY 2006.

During FY 2007, the Maryland Motor Vehicle Administration ("MVA") collected $12.9 million from the $5 surcharge on motor vehicle renewals. Disbursements from the Trauma Fund significantly increased in FY 2007 as a result of the passage of House Bill 1164. The Trauma Fund paid trauma physicians and trauma centers $13.1 million for uncompensated care, Medicaid under-compensated services, trauma on-call expenses, and trauma grants. The Fund also held $3.0 million in claims for uncompensated care, on-call, and standby expenses that were incurred, but not paid during the fiscal year. The balance in the Trauma Fund remained at approximately $20 million at the end of FY 2007, or $17.5 million if incurred but not paid obligations were netted against the Fund.

The MHCC estimates MVA collections through the $5 fee should increase by about 2 percent per year in 2008 and 2009. Projected spending under current law will be about __ or percent below collections from the MVA. The Fund balance is projected to increase by about $1.5 million over the next several years. MHCC recommends that the General Assembly grant MHCC flexibility to disburse Trauma Fund balances on trauma equipment grants and for adjusting physician fees to ensure broad participation in the Trauma System. The $275,000 cap on reimbursement to emergency medicine should be removed as no other specialty operates under with a limitation on uncompensated care. These changes require modification to the statute. MHCC recommends a limited expansion in the eligibility of on-call

payments. That modification will apply to Level I trauma centers and referral centers and can be accomplished through a regulatory change.

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 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 for reimbursement for the uncompensated care and Medicaid under-payment from the Fund. Secondly, thresholds for on-call payments were designed to partially cover total on-call expenses. This is consistent with the language in the law that directs the MHCC to continue to provide incentives to trauma center 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 three 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

[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 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] Prior to February 2007, physician practices and trauma centers submitted applications for reimbursement biannually on January 31st and July 31st for the previous 6 month period. The 6 month reporting lag meant that services provided in the last half of each fiscal year were paid in the following fiscal year. The MHCC netted 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.

result, the under-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. 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 17 of this report.

Status of the Fund at the End of FY 2007

The Trauma Fund disbursed about $12.7 million to trauma centers and trauma physician practices over the past fiscal year. Table 1 summarizes the revenues, disbursements, and the Fund balance at the end of FY 2007.

Table 1 - Trauma Fund Status on a Cash Flow Basis

CATEGORY	AMOUNT
Fund Balance Start of FY 2007 (July 1, 2006)	$20,804,948.76
Collections in FY 2007 from the $5 Registration Fee	$12,963,423.84
Total Fund Balance before FY 07 Expenditures	$33,768,372.60
-- Trauma Equipment Grants	-$2,963,383.00
-- Uncompensated Care Payments	-4,724,998.29
-- On-Call Expenses	-4,697,218.34
-- Medicaid Payments through 06/30/07	-322,622.68
-- Children's National Medical Center Grant for Standby Expenses	-275,000.00
-- Audit Expenses	-70,678.18
-- TPA Expenses	-146,928
Adjustments (Medicaid refunds due to overpayments)	$655.38
Total Expenditures	-$13,200.173.11
TRAUMA FUND BALANCE FY END June 30, 2007	$20,568,199.49

Collections by the MVA via the $5 surcharge grew from about $12.5 million to $12.9 million in 2007, a 3.2 percent increase. At the end of the fiscal year, the Fund balance was $20.6 million, down from roughly $20.8 million in 2006.

Outstanding Obligations for FY 2007

The Fund held outstanding obligations that totaled approximately $3.1 million, which are not reflected in the FY 2007 year end balance. These obligations result from provider applications for uncompensated care, on-call, and standby expenses for services provided in FY 2007. A reconciliation of these applications leaves a Fund balance of $17.5 million after all obligations are paid. The $4.0 million paid for uncompensated care and on-call stipends are the highest payments made by the Fund in any bi-annual filing period. MHCC attributes this 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 previous fiscal years.

Table 2 – FY 2007 Obligations Incurred after Year End

TRAUMA FUND BALANCE END June 30, 2007	$20,568,199.49
Uncompensated Care Incurred but not Paid by June 30, 2006	301,840.45
On-call Incurred but not Paid by June 30, 2007	2,541,344.30
Children's National Medical Center FY 2007 Standby Expenses	490,000.00
TOTAL INCURRED BUT NOT PAID IN 2007	3,333,184.70
REAL 2007 BALANCE (including costs incurred by not paid)	$17,235,014.74

Implementing House Bill 1164

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 have been implemented as shown in Table 3.

Table 3 – Implementation of the 2006 Statutory Changes

	Date Implemented	Comments
Changes Requiring Modifications to COMAR 10.25.11		
Expand eligibility to the Fund to all physicians providing trauma	7/1/2006	TPA began processing in February 2007.
Increase On-call Payment to Level II and Level III Trauma Centers	7/1/2006	First payment made in March 2007 for call provided 7/1/2006-12/31/2006
Replace the per specialty limit on on-call hours with a per center limit on hours	7/1/2006	
Expand the Uncompensated Care Payments to include Johns Hopkins Burn Centers	7/1/2006	
Expand uncompensated care payments to include Johns Hopkins Eye Trauma at Wilmer Eye Center and the Hand Trauma Center at Union Memorial.	12/1/2007	Centers will begin submitting data to a MIEMSS registry in December 2007.
Self-implementing Changes		
Award a one-time standby grant to Union Memorial Hand Center	1/31/2007	$177,943 awarded in spring of 2007
Award one-time trauma grant(s) for $3 million	1/10/2007	Awarded 3/31/2007 grants to 7 Level II and III Trauma Centers
Expand the ceiling on the Standby expense stipend at Children's National Medical Center to $490,000.	7/1/2007	First application received September 2007

Regulatory Changes to COMAR 10.25.11

The MHCC adopted emergency and proposed regulatory changes to 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 became effective in December of 2006. The implementation of House Bill 1174 is described in the respective under the elements of the system that were affected.

Payment to Practices for Uncompensated Trauma Care

Uncompensated trauma care services are reimbursed at 100 percent of the Medicare rate for the service in the Baltimore area pricing locality. Before applying for uncompensated care payments, a practice must apply its routine collection policies, 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 therefore eligible for uncompensated care reimbursement. This requirement is consistent with the legislative intent, which made the Fund the payer of last resort for practices providing trauma services. Table 4 presents the distribution of uncompensated care by the trauma center in which the care was provided since the inception of claims adjudication by the Commission's third party administrator in February 2007.

Table 4 -- Uncompensated Care Trauma Fund Payments by Trauma Centers from February 2007 through June 30, 2007

Facility	Payments	% of Uncompensated Care Payments
R. Adams Cowley Shock Trauma Center	$804,536.94	25.5%
Johns Hopkins Hospital	$740,925.30	23.5%
Prince George's Hospital Center	$534,799.74	17.0%
Johns Hopkins Bayview Medical Center	$291,630.82	9.2%
Sinai Hospital	$167,005.35	5.3%
Peninsula Regional Medical Center	$163,786.38	5.2%
Suburban Hospital	$126,142.72	4.0%
Washington County Hospital	$101,738.85	3.2%
Johns Hopkins Regional Burn Center	83,230.09	2.6%
Johns Hopkins Medical Center Pediatric Trauma Center	$66,696.58	2.1%
Maryland Eye Trauma Center	$58,261.09	1.8%
Western Maryland Health System	$12,560.42	0.4%
TOTAL	$3,128,753.66	100.0%

Note: Uncompensated care payments made prior to February 2007 cannot be precisely assigned to a center.

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 have been developed for these specialty centers so that equivalent registries as a cross check on eligibility for uncompensated or Medicaid elevated payments.

Beginning in FY 2007, the Trauma Fund reimbursed physicians for follow-up care provided after the initial 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. To be considered for payments, services must be provided in a hospital setting.

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.

Payment for Services Provided to Patients Enrolled in Medicaid

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. 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 especially for Medicaid Managed Care Organization (MCO) beneficiaries.

Table 5 – Trauma Fund Payments to Medicaid

Service Period	Amount Billed
June 2006	$41,687.49
July 2006	$29,754.70
August 2006	$29,522.06
September 2006	$20,025.21
October 2006	$15,685.60
November 2006	$21,553.66
December 2006	$40,825.49
January 2007	$35,979.44
February 2007	$17,250.57
March 2007 – Payment to MCO's	$108,761.25
Total	$322,622.68

Payment for Trauma On-Call Service

Hospitals reimburse physicians for taking call or serving standby.[5] 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 dependent on local market factors. Shortage of certain surgical specialties, especially in rural areas, may push payments higher. An ample supply of physicians may eliminate the need to offer payments. The need to ensure physician availability is especially acute in trauma care. Most trauma center hospitals reimburse physicians when they provide on-call services, and certainly do so 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-call and able to respond within 30 minutes.[6]

On-call expenses were reimbursed for the number of on-call hours provided up to a maximum of 35,040 hours per year. 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 a physician is called to the hospital and generating billable services, the hospital does not reimburse for on-call. Several of the Level III trauma centers do not pay call for anesthesiologist for this reason. Other trauma hospitals maintained orthopedists or neurosurgeon availability without paying on-call stipends.

[5] 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.

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

Table 6 – On-Call Payments to Level II and Level III Trauma Centers

Trauma Facility	FY 2007
	Total Paid
Level II	
Johns Hopkins Bayview Medical Center	$623,303
Prince George's Hospital Center	401,763
Sinai Hospital of Baltimore	490,654
Suburban Hospital	522,824
Union Memorial	177,951
Level III	
Peninsula Regional Medical Center	1,022,336
Washington County Hospital Association	880,705
Western Maryland Health System	577,682
TOTAL	$4,697,228
Note: Union Memorial received a standby grant of $300,000 under HB 1164, $177,951 was paid in FY 2007.	

Trauma Equipment 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 grant program, each center was eligible for up to $425,000 for equipment used in trauma care, 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 grant application required the centers to document intended equipment purchases and to report the percent of time that the equipment will be used in trauma care. 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 all risks and benefits associated with ownership are transferred to the hospital.[7]

Funds were disbursed once a grant application was reviewed and approved by a panel composed of a representative from each of the three state agencies. The centers are 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 the grant process will be met. Total one time equipment grants made by MHCC during FY 2007 were $2,963,383.

The MHCC reported to the Senate Finance and House Health and Government Operations Committees on the grant program prior to awarding any grants as was required under HB 1164.

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 7 presents the amount each hospital received in its hospital charges effective July 1, 2006 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.

[7] 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 exceed 90% of the fair market value (FMV) of the asset at lease inception.

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 2007

	Inpatient	Outpatient	Total $
Johns Hopkins Hospital	$661,927	$ 99,732	$ 761,659
Prince George's Hospital Center	1,271,798	36,286	1,308,084
Sinai Hospital	508,474	420,460	928,934
Suburban Hospital	358,222	166,968	527,900
Peninsula Regional Medical Center	-	-	-
Washington County Hospital	414,181	202,055	616,236
Western Maryland Health System	247,732	50,614	298,346
Total	$ 3,462,334	$ 976,115	$ 4,441,159

Note: Peninsula Regional Medical Center reports no standby costs. Approximately $4,127,800 in standby expense was included in FY 2006; the difference in FY 2007 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 $490,000 to Children's National Medical Center (CNMC, Children's) for providing standby services that are used by Maryland trauma patients. The annual grant increased from a maximum allowable stipend of $275,000 as a result of changes at the close of the 2006 legislative session. Children's reported approximately $1.2 million in comparable standby expenses for FY 2007, as well as approximately $1.2 million in comparable standby expenses for which it received the maximum allowable stipend of $275,000 in FY 2006. The initial payment for $490,000 will appear disbursements in FY 2008 as the FY application was received in September 2007.

MHCC Administrative Expenses

The MHCC incurs personnel and contract costs associated with the administration of the Fund. The MHCC has never sought reimbursement for personnel costs associated with administration f the Fund. In the original bill establishing the Fund, MHCC had been allotted 1 full-time equivalent (FTE), that

FTE was removed in FY 200 during a round of staff reductions. About 50 percent of a FTE was dedicated to Fund activities in 2007. Much of the expense was attributable to activities related to the expansion of the Fund including program and contract development and provider education. The MHCC incurs additional contract expense related to the administration of the Fund. These costs are charged to the Fund.

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 July 1, 2006 through December 31, 2006. During that period, the auditor identified $77,110 in recoveries for the Trauma Fund 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.

Use of a Third Party Administrator (TPA)

HB 1164 expanded the number of specialties eligible for reimbursement by the Fund. Staff estimated that the number of eligible practices would likely double. As the former reimbursement application was 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 claims. This process includes 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 was needed. The MHCC completed an RFP to identify an administrator to process claims from physician practices that provide uncompensated trauma services. MHCC released a contract on October 3, 2006 and awarded a contract to CoreSource, Inc., with offices in White Marsh, Maryland on December 1, 2006. CoreSource began accepting claims in February 2007.

The transition to claim submission using a TPA proved difficult for some practices. MHCC required practices to provide documentation on the claim that confirmed the patient was treated for trauma, that the patient had no health insurance, and that the practice had made attempts to collect the bill (usually reflected in repeated bills sent to the patient). Some practices failed to provide the required information, causing the TPA to return claims to the practice for correction and resubmission. This problem, coupled with an unexpected surge in claim volume, produced a significant backlog of claims. In April, more than 5,000 claims were awaiting adjudication. The TPA eliminated the backlog over the next six weeks. The volume of claims submitted over the first five months of TPA operations has been significantly higher than the 7,000 claims per year originally projected. At the end of June, over 12,000 claims had been processed.

Revenue and Spending Outlook

Table 8 presents estimated revenue (collections from the $5. motor vehicle surcharge) and disbursements for 2008 and 2009. Actual revenue and payments for FY 2007 are provided as a point of reference. The MHCC estimates that revenue will continue to increase 2 percent annually through 2009. This estimate is consistent with the slowing revenue growth in the Fund. From 2004 through 2007 collections climbed from $10.4 million to $12.9 million, but grew just over 3 percent 2006 to 2007.

Table 8 - Trauma Fund Spending 2007- 2009

	Actual FY 2007	Projected FY 2008	Projected FY 2009
Carryover Balance from Previous Fiscal Year	**$20,804,949**	**$20,568,179**	**$21,720,424**
Collections from the $5. surcharge on automobile renewals	**$12,963,424**	**$13,222,692**	**$13,487,146**
TOTAL BALANCE and COLLECTIONS	**$33,768,373**	**$33,790,872**	**$35,207,570**
Payments to Trauma Physicians			
Uncompensated Care	**($4,724,998)**	**($5,250,000)**	**($5,775,000)**
Medicaid Under-payments	**($322,623)**	**($330,688)**	**($337,302)**
Payments to Trauma Centers			
On-call Payments to Level II and Level III Trauma Centers	**($4,697,218)**	**($5,699,760)**	**($6,104,443)**
Standby Payment to Children's National Medical Center	**($275,000)**	**($490,000)**	**($490,000)**
Trauma Equipment Grants to Level II and Level III Centers	**($2,963,383)**		
MHCC Administrative Expenses (TPA & Audit)	**($216,971)**	**($300,000)**	**($300,000)**
TOTAL DISBURSEMENTS	**($13,200,193)**	**($12,070,448)**	**($13,006,745)**
Fiscal Year End Balance	**$20,568,179**	**$21,720,424**	**$22,200,825**

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

Uncompensated care payments will continue by approximately 10 percent in 2008 and 2009. The projected growth includes an estimated 1.5 percent increase in physician fees under Medicare in each of the years. Medicare fees are scheduled to fall. However, Congress has intervened to keep Medicare physician fees from falling since the establishment of the Sustainable Growth Rate (SGR). Spending attributable to increases in the volume of uncompensated care services are estimated at approximately 7 percent yearly. This expansion will largely be driven by increased claims attributable to physicians growing awareness about the Trauma Fund. In FY 2007, the Trauma Fund started reimbursing physicians for follow-up care provided after the initial hospitalization. These changes have benefitted

physicians that provide substantial care after the initial trauma hospitalization including plastic surgery, ophthalmic, oral, maxillofacial, and orthopedic surgery. Burn care treatment, in particular, can extend for a considerable time after the initial injury. MHCC expects these specialties to provide the bulk of addition claims for payment as awareness improves.

On-call stipends are projected to grow by over 20 percent in 2008 and by about 10 percent in 2009. This growth includes an estimated 2 percent inflation adjustment based on the physician compensation component of the Medicare Economic Index.

All of the trauma center hospitals had allowable on-call expenses below the payment ceiling in FY 2007. A number of trauma centers substituted standby for on-call which reduces on-call stipends. For example, Level III centers are required to have an anesthesiologist on-call and able to respond within 30 minutes, but two of the Level III trauma centers keep an anesthesiologist in the hospital due to the high demand for surgical services at the hospital.

Other categories of disbursements covered by the Trauma Fund are capped in the statute or will experience little growth. The standby stipend for the Children's National Medical Center Trauma Center in Washington MHCC is capped at $490,000. MHCC projects Medicaid underpay to remain stable throughout the period. The Maryland Patients' Access to Quality Health Care Act passed in the 2004 session requires the DHMH to raise physician fees under Medicaid to 80-100 percent of Medicare fees.

The Trauma Fund balance will increase by approximately $1.2 million in 2008 and another $500,000 in 2008. Under current spending assumptions, the collections from the MVA and payments to providers will near balance in FY 2009.

Recommendation For Reducing The Balance In The Fund

HB 800 passed in the 2007 session of Maryland General Assembly requires the MHCC to recommend options for reducing the Fund balance in the Annual Report to the House Health and Government Operations and Senate Finance Committees. MHCC developed proposed recommendations for reducing the balance in August 2007. A meeting with trauma providers and MIEMSS was held in August of 2007 to seek input on the recommendations. Table 9 summarizes the ten options that MHCC considered, provides costs estimates, and identifies a justification for adoption or rejection. The

first three recommendations shown in Table 9 can be accomplished by changes to regulations governing the Trauma Fund (COMAR 10.25.11). Recommendations 1 and 2 would permit the Fund to reimburse the Level I Trauma Center and the three specialty referral centers for on-call expense. Use of on-call in these centers is quite rare, although a 3rd or 4th year post graduate (PGY) year resident could substitute for an attending physician, if the physician is available to respond to a call within 30 minutes. The third recommendation will allow physicians that care for uninsured trauma patients in a rehabilitation hospital setting to receive uncompensated care payments. The current regulations do not specify rehabilitation hospitals as a place of service. These hospitals were not included as a permitted site of care because of concerns that demand on the Trauma Fund would exceed collections.

The next recommended change would remove the $275,000 cap on total payments to emergency medicine physicians. This provision is an artifact of the original law when demand on the Fund was a primary concern. Emergency medicine is the only specialty that has a spending ceiling The transfer of claim adjudication to a TPA makes identification of physician specialty difficult because specialty is not routinely collected on a claim This change required legislative action. Trauma providers and MIEMSS support the removal of this provision in the law.

The next two recommendations allow MHCC more flexibility in responding to needs from trauma providers. Current law states that the MHCC is 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 law is very specific on how these concerns should be met. Given that Fund balances change, more flexibility resting with the MHCC will lead to more efficient Fund administration. Recommendation 5 would permit MHCC to use Fund balances for trauma equipment grants with the stipulation that total grant cannot exceed 15 percent of the existing balance in any year. MHCC awarded each Level II and III center a $425,000 grant in FY 2007. Most hospitals identified well over $425, 000 in equipment needs. Using grants to reduce Fund balances will eliminate the need to seek legislative changes every 2-3 years. This change is supported by trauma providers and MIEMSS. Recommendation 6 will permit MHCC to adjust reimbursement levels for uncompensated care. Uncompensated care is currently reimbursed at 100 percent of the Medicare Fee Schedule in the Baltimore locality.

Table 9 – Options for Spending the Balance in the Trauma Fund

	Fiscal Impact	Type of Change	Comments
Recommended			
1. Permit the Level I Trauma Center and Pediatric Trauma Center in the State to receive stipends for on-call provided by anesthesiologists, trauma surgeons, orthopedic surgeons, or neurosurgeons.	$300,000	Regulatory	Level I trauma centers may have PGY resident in hospital with a physician on-call.
2. Permit the 3 specialty referral centers to receive on-call stipends for the specialty at the Level II on-call rate.	$300,000	Regulatory	
3. Permit physicians to receive uncompensated care payments for trauma service provided to a patient at a rehabilitation hospital.		Regulatory	
4. Remove the $275,000 cap on uncompensated care for emergency medicine physicians	Minimal	Requires a change in the statute	
5. Permit MHCC to award grants for trauma related equipment and systems	Up to $3 million	Requires a change in the statute	Cap at a maximum of 15% of the existing balance in the Fund.
6. Permit MHCC to adjust fee levels for uncompensated care		Requires a change in statute	
Not Recommended			
7. Require trauma centers hospitals to administer the reimbursement of physicians for providing uncompensated care trauma services at the hospital	($200,000)	Requires a change in the law	Reduces MHCC administrative costs. Opposed by trauma providers
8. Expand the specialties eligible for on-call.	$3,500,000	Requires a change in the law	
9. Allow physicians to bill for office services	$500,000		Most office services are included in surgery services under the Medicare Fee Schedule. Not favored by current trauma providers.
10. Permit allied health professionals (AHP) to bill for uncompensated care services	258,000		Hospital- based AHP are salaried. No office-based care is subsidized.

Other Options For Reducing the Fund Balance

Allow hospitals to distribute UC funds directly to practices. MHCC is required by HB Bill 800 to report on this option. TraumaNet did not believe it was desirable to have hospitals distribute uncompensated trauma care funds to physicians. MHCC makes no recommendation.

Permit physicians to receive uncompensated care payments for office-based services related to the original trauma. MHCC analysis indicates this option will have limited impact as most trauma surgical services are bundled to include the office component.

Allow non-physician providers to be reimbursed by the Fund.

Appendices

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

Prior Years' FY04 thru FY06 Total Revenue	$ 34,658,682.07
Jul-06	971,401.50
Aug-06	1,196,071.83
Sep-06	1,061,721.47
Oct-06	991,997.20
Nov-06	1,081,552.81
Dec-06	812,730.14
Jan-07	1,003,725.12
Feb-07	880,881.27
Mar-07	1,109,205.62
Apr-07	1,251,393.15
May-07	1,147,148.95
Jun-07	1,455,594.78
Subtotal—YTD	12,963,423.84
Total Collected Since Fund Inception	$ 47,622,105.91

Note: Monthly totals include interest earned during the month.

Appendix Table 2 Uncompensated Care Payments Made in FY 2007

Physician Name	PAID Sum	Percent of Total
Andrew Panagos	$725.75	0.02
Bahman Sadr, MD	$2,936.93	0.06
Bethesda Emergency Associates, LLC	$5,234.81	0.11
Betsy Ballard, MD	$38,191.91	0.8
Bijan Bahmanyar	$91,757.22	1.92
Boyd E. Sprenkle, M.D.	$1,849.73	0.04
Brajendra Misra	$81,073.22	1.7
Center for Joint Surgery & Sports Medicine	$3,371.39	0.07
Central ENT Clinic	$8,844.43	0.19
Cumberland Emergency Med Grp	$5,931.97	0.12
Dino Delaportas	$4,847.08	0.1
Emergency Service Associates	$124,663.74	2.61
Enrique Daza, MD	$82,235.75	1.72
Ernest Hanowell, MD, PC	$19,847.02	0.42
Falik & Karim, MDS, PA	$96,742.02	2.02
First Colonies Anes, LLC	$27,217.94	0.57
Intensimed LLC	$86,098.88	1.8
JHU, Clinical Prac. Assoc.	$1,511,023.10	31.63
James Robey	$6,264.84	0.13
Jeffrey Meunch	$83,804.61	1.75
Konrad Dawson	$40,962.97	0.86
Mark A. Sagin, MD	$1,120.38	0.02
Mid-Atlantic Orthopaedic Spec	$3,790.77	0.08
Mohammad Ali Khan, M.D.	$110,201.56	2.31
Montaque Blundon III	$56,805.74	1.19
Mosam Cardiovascular Surgery	$18,779.77	0.39
Neurosurgical Specialists LLC	$64,433.64	1.35
Orthopaedic Associates LLP	$15,939.03	0.33
PGHC Anesthesia Assoc	$36,215.60	0.76
Paul Olumuyiwa	$70,966.70	1.49
Peninsula Neurosurgical Assoc	$17,303.77	0.36
Peninsula Orthopaedic Associates, PA	$7,920.21	0.17
Rajindar S. Sidhu	$4,425.34	0.09
Ramin Jebraili	$23,170.90	0.48
Richard Pyrfrom	$7,285.14	0.15
Sagar V. Nootheti, MD, PA	$30,251.11	0.63
Said A Daee MD PA	$109,320.05	2.29
Shock Trauma Associates PA	$420,757.78	8.81
Sinai Surgery Assoc	$37,526.15	0.79
Sterling Anesthesia OD MD	$18,525.11	0.39
Sylvanus Oyogoa	$111,933.37	2.34

Trauma Surgery Associates	$58,050.48	1.21
Trauma Surgical Assoc	$88,877.34	1.86
University of MD Anesthesia Assoc., PA	$2,654.45	0.06
University of MD Neurosurgery Assoc., PA	$16,367.47	0.34
University of MD Oral Maxial Surgical Associates	$47,888.73	1
University of MD Ortho Trauma Assoc.	$652,275.46	13.65
University of MD Orthopaedics Assoc., PA	$23,650.95	0.5
University of MD Pathology Assoc., PA	$148.62	0
University of MD Physicians, PA	$916.77	0.02
University of MD Surgical Assoc., PA	$282.29	0.01
University of MD Diagnostic Imag. Spec. PA.	$65,463.14	1.37
Vicki Reese, M.D.	$51,488.02	1.08
Victor Wowk	$20,553.71	0.43
Vincent Casibang	$59,921.00	1.25
Washington Cardiothoracic Surgery	$6,908.57	0.14
Washington County Emergency Medicine Phys	$31,054.31	0.65
Washington County Hosp Phys	$68,531.42	1.43
Wendell Miles	$5,883.15	0.12
Western Maryland Trauma Assoc	$12,233.48	0.26
Willie C. Blair, MD	$49,146.57	1.03
Yardmore Emergency Physicians	$19,194.83	0.4
Zachary Levine, M.D.	$6,081.50	0.13