MARYLAND TRAUMA PHYSICIAN SERVICES FUND

Health General Article § 19-130

Operations from July 1, 2007 through June 30, 2008

Report to the

MARYLAND GENERAL ASSEMBLY

Marilyn Moon, Ph.D.
Chair

Rex W. Cowdry, M.D.
Executive Director
Maryland Health Care Commission

Donald Young, M.D.
Chairman

Robert Murray
Executive Director
Health Services Cost Review Commission

Prepared by the
Maryland Health Care Commission

Table of Contents

Executive Summary 4
Background 5
Status of the Fund at the End of FY 2008 6
Outstanding Obligations for FY 2008 7
Implementing Senate Bill 916 8
Payment to Practices for Uncompensated Trauma Care 9
Payment for Services Provided to Patients Enrolled in Medicaid 10
Payment for Trauma On-Call Service 11
Trauma Equipment Grant Program 12
HSCRC Standby Expense Allocation 13
Payment to Children's National Medical Center for Standby Expense 14
MHCC Administrative Expenses 14
Audit Expenses 14
Use of a Third Party Administrator (TPA) 15
Revenue and Spending Outlook 15
Appendix Table 1 18
Maryland Motor Vehicle Registration Fees 18
Appendix Table 2 20
Uncompensated Care Payments Made in FY 2008 20

This annual report on the Maryland Trauma Physicians Services Fund for fiscal year 2008 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.

In the last three years, the Maryland General Assembly has taken action to increase eligibility for trauma funds. House Bill 1164 (Trauma Reimbursement and Grants) passed during the 2006 session of the Maryland General Assembly realigned spending with collections by increasing the physician specialties eligible for uncompensated care 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. Grants of $430,000 were awarded to each hospital in FY 2007. Level II and Level III trauma center hospitals had until the end of FY 2008 to use the funds. All seven centers reported disbursing their grants by the end of FY 2008. Senate Bill 916 (Maryland Trauma Physician Services Fund – Reimbursements and Grants) passed in the 2008 session of the Maryland General Assembly expanding eligibility for Trauma Fund on-call payments, making the trauma equipment grant program permanent subject to funds available, and giving the MHCC authority to raise physician reimbursement levels. These changes will align spending and revenue and provide a mechanism for spending down the current Trauma Fund balance.

During FY 2008, the Maryland Motor Vehicle Administration ("MVA") collected $12.9 million from the $5 surcharge on motor vehicle renewals (including interest). Payments for uncompensated care and on-call increased in FY 2008 to $12.7 million for uncompensated care, Medicaid under-compensated services, trauma on-call expenses, and administrative expenses. The Fund also held $3 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 2008, or $17 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 approximately equal to collections from the MVA. The Fund is projected to be in balance over the next several years.

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

[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.

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-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. The new law 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 "Revenue and Spending Outlook" beginning on page 15 of this report.

The General Assembly enacted further changes to the Fund in 2008, with an effective date of July 1, 2008. The changes, which will be reflected in the FY 2009 Annual Report, include expanding on-call payments to permit the Level I Trauma Center and the Pediatric Trauma Center to receive stipends for on-call; expanding uncompensated care payments for care provided at trauma center-affiliated rehabilitation hospitals; granting of awards for Level II and Level III centers for trauma related equipment and systems; an increase in the annual grant to Children's National Medical Center to subsidize stand-by costs; and permitting MHCC, in consultation with HSCRC, to adjust uncompensated care and on-call rates.

Status of the Fund at the End of FY 2008

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 2008.

Collections by the MVA via the $5 surcharge were $12.9 million, the same as collected in 2007. At the end of the fiscal year, the Fund balance was $20.5 million, down $300,000 from the Fund balance in 2007.

Table 1 - Trauma Fund Status on a Cash Flow Basis

CATEGORY	AMOUNT
Fund Balance Start of FY 2008 (July 1, 2008)	$20,804,949
Collections in FY 2008 from the $5 Registration Fee (and interest)	$12,919,892
TOTAL Fund Balance before FY 08 Expenditures and Credits	**$33,724,840**
-- Uncompensated Care Payments	(6,751,938)
--Credit Recoveries	453,508
-- On-Call Expenses	(5,258,097)
-- Medicaid Payments through 06/30/08	(273,003)
-- Children's National Medical Center Grant for Standby Expenses	(490,000)
-- Administrative Expenses	(467,892)
Total Expenditures	**($12,787,422)**
Transfer of interest to MHCC*	(124,047)
Applied to 2007 deficiency**	(259,273)
TRAUMA FUND BALANCE FY END June 30, 2008	**$20,554,098**

NOTES:

*The Fund was charged interest on its operating account. Funds were not transferred until year end.

** In 2007, the disbursement exceeded the appropriation. Funds to close the deficiency were withdrawn from the Fund balance in FY 2008.

Outstanding Obligations for FY 2008

The Fund held outstanding obligations that totaled approximately $3.5 million, which are not reflected in the FY 2008 year-end balance. These obligations result from provider applications for uncompensated care, on-call, and standby expenses for services provided in FY 2008. A reconciliation of these applications leaves a Fund balance of $17 million after all obligations are paid. The $12.7 million paid for uncompensated care and on-call stipends are the highest payments made by the Fund in any filing period. MHCC attributes this to increased awareness about the Fund, rather than skyrocketing uncompensated care.

Table 2 – FY 2008 Obligations Incurred after Year End

TRAUMA FUND BALANCE END June 30, 2008	**$20,544,098**
Uncompensated Care Incurred but not Paid by June 30, 2008	(198,660)
On-call Incurred but not Paid by June 30, 2008	(2,769,819)
Children's National Medical Center FY 2008 Standby Expenses	(490,000)
TOTAL INCURRED BUT NOT PAID IN 2008	(3,458,479)
2008 BALANCE (including claims incurred by not paid)	**$17,085,619**

Implementing Senate Bill 916

The Maryland General Assembly passed HB 916 (Maryland Trauma Physician Services Fund - Reimbursement and Grants) toward the end of the 2008 Session of the Maryland General Assembly. The key provisions are shown in Table 3.

Table 3 – Key Provisions of Senate Bill 916

Statutory Changes	Estimated Costs in FY 2009	Comments
1. Permits the Level I Trauma Center and Pediatric Trauma Center to receive stipends for on-call provided by trauma surgeons, orthopedic surgeons, and neurosurgeons up to 4,380 hours per year.	$500,000	Level I trauma centers may have a Post Graduate Year (PGY) 3-4 resident in the hospital with a physician on-call.
2. Permits the three specialty referral centers to receive on-call stipends for their specialty up to 2,190 hours per year.	$300,000	Allows Curtis National Hand Center at Union Memorial to reimburse for on-call for a hand surgeon; Wilmer Eye Center to reimburse for on-call for an Ophthalmologist; and JHH Bayview to reimburse for on-call for a burn trauma surgeon.
3. Permits physicians to receive uncompensated care payments for care provided at a trauma center-affiliated rehabilitation hospitals.	Minimal	Incentivizes use of most appropriate and lower cost care. Affects Kernan, Mt Washington, and Levindale.
4. Raises the cap on uncompensated care reimbursement for emergency medicine physician practices.	Minimal	Legislative intent was to put $300,000 limit on any practice.

5. Permits MHCC to award grants to Level II and Level III centers for trauma related equipment and systems.	$2 million (maximum)	Capped at a maximum of 10% of the existing balance in the Fund at the FY end immediately prior to the FY in which grants are awarded. In 2008, TF could award about $2 million in grants.
6. Permits MHCC, in consultation with HSCRC, to adjust uncompensated care and on-call rates.	Allows flexibility in balancing the Fund	The Commission had a limited ability to manage the Fund under the previous law. MHCC may establish a rate for uncompensated care reimbursement that is above 100% of the Medicare rate for the service, if it determines that a higher rate would address unmet need in the State trauma system and it reports to the Senate Finance & House Government Operations Committees at least 60 days before adjusting the rate.
7. Increases the annual grant to subsidize stand-by costs at Children's National Medical Center to $590,000.	$590,000	Increase of $100,000 from the current stand-by rate cap.

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 during FYs 2007 and 2008.

Table 4 -- Uncompensated Care Incurred or Incurred and Paid, FYs 2007 and 2008

Facility	% of Uncompensated Care Payments FY 2007	% of Uncompensated Care Payments FY 2008
R. Adams Cowley Shock Trauma Center	25.5%	41.1%
Johns Hopkins Hospital	23.5	19.9
Prince George's Hospital Center	17.0	12.0
Johns Hopkins Bayview Medical Center	9.2	7.6
Suburban Hospital	5.3	4.9
Peninsula Regional Medical Center	5.2	3.9
Sinai Hospital	4.0	3.1
Maryland Eye Trauma Center	3.2	2.2
Johns Hopkins Regional Burn Center	2.6	2.0
Johns Hopkins Hospital Pediatric Center	2.1	1.5
Washington County Hospital Center	1.8	1.4
Western Maryland Health System	0.4	0.4

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 will serve 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-effective 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 or trauma-center affiliated rehabilitation hospital setting.

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
November 2007	$40,537.32
February 2008	32,865.05
April 2008	55,678.81
June 2008	143,921.86
TOTAL	**$273,003.04**

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 anesthesiologists 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 2008
Johns Hopkins Bayview Medical Center	$755,396
Prince George's Hospital Center	512,751
Sinai Hospital of Baltimore	617,112
Suburban Hospital	606,063
Union Memorial	121,973
Peninsula Regional Medical Center	1,115,205
Washington County Hospital Association	967785
Western Maryland Health System	561,812
TOTAL	$5,258,097

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]

[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.

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

As a result of SB 916, the MHCC, in conjunction with HSCRC and MIEMSS, is developing a process for annual trauma equipment grants.

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, increased by the annual factor of 4.25%. The Commission used the Reasonable Cost Equivalent (RCE) methodology employed by Medicare in determining reasonable allowable standby costs.

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 7- Maryland Trauma Standby Costs in HSCRC-Approved Rates FY 2008

Trauma Center	Inpatient	Outpatient	Total $
Johns Hopkins Hospital	$690,059	$ 103,971	$ 794,030
Prince George's Hospital Center	1,325,849	37,828	1,363,677
Sinai Hospital	530,084	438,330	968,414
Suburban Hospital	373,446	174,064	547510
Peninsula Regional Medical Center	-	-	-
Washington County Hospital	431,784	210,642	642,426
Western Maryland Health System	258,261	52,765	311,026
Total	**$ 3,609,483**	**$ 1,017,600**	**$ 4,627,083**

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 20078 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 $1.1 million in comparable standby expenses for FY 2008, as well as approximately $1.2 million in comparable standby expenses for which it received the maximum allowable stipend of $490,000 in FY 2007. The FY 2008 payment for $490,000 will appear in disbursements in FY 2009 as the FY application was received in September 2008.

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 of the Fund. Approximately one FTE was dedicated to Fund activities in 2008. 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, 2007 through December 31, 2007. The Trauma

Fund recovered $134,395 as a result of the uncompensated care audits during FY 2008. Clifton Gunderson, LLP is also conducting an audit of on-call reimbursement. No findings have been reported to the Commission as a result of that audit to date. 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 awarded a contract to CoreSource, Inc., with offices in White Marsh, Maryland, on December 1, 2006. CoreSource began accepting claims in February 2007.

Revenue and Spending Outlook

Table 8 presents estimated revenue (collections from the $5 motor vehicle surcharge) and disbursements for 2009 and 20010. 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.

Uncompensated care payments are projected to increase by approximately 10 percent in 2009. The projected growth includes an estimated 1.5 percent increase in physician fees under Medicare. Medicare fees were 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 began 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.

Table 8 – Projected Trauma Fund Spending 2009-2010

	Projected FY 2009	Projected FY 2010
Carryover Balance from Previous Fiscal Year	$20,554,098	$18,395,093
Collections from the $5 surcharge on automobile renewals	13,274,692	13,487,146
TOTAL BALANCE and COLLECTIONS	33,828,790	31,882,239
Payments to Physicians for Medicaid and Uncompensated Care	(6,752,937)	(6,775,000)
Payments to Hospitals for Call and Standby	(6,190,760)	(6,594,443)
MHCC Administrative Expenses (TPA & Audit)	(490,000)	(500,000)
TOTAL DISBURSEMENTS	(13,433,697)	(13,869,443)
Trauma Equipment Grants	(2,000,000)	(1,800,000)
PROJECTED YEAR-END BALANCE	$18,395,093	$16,212,796

On-call stipends are projected to grow by about ten percent in 2009. This growth includes an estimated two 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 2008. 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. MHCC projects Medicaid underpayment to remain stable throughout the next two years. 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.

Under current spending assumptions, the collections from the MVA and payments to providers will nearly balance in FY 2009.

Appendices

Appendix Table 1

Maryland Motor Vehicle Registration Fees Collections per Month, FY 2008

Month	Total Revenue
Jul-07	997,860
Aug-07	1,230,508
Sep-07	1,018,656
Oct-07	1,165,010
Nov-07	873,370
Dec-07	804,813
Jan-08	886,575
Feb-08	848,352
Mar-08	974,436
Apr-08	1,065,209
May-08	984,937
Jun-08	1,063,981
Interest, FY to date	1,006,182
Total	$12,919,889

Appendix Table 2

Uncompensated Care Payments Made in FY 2008

Physician Name	Amount Paid	Percent
Andrew Panagos	$1,870	0.0%
Anuradha Kulkarni	5,180	0.1
Associated Anesthesia Practice, PA	16,644	0.2
Bethesda Chevy Chase Orthopaedic Associates, LLP	7,557	0.1
Betsy Ballard	20,526	0.3
Bijan Bahmanyar	115,206	1.6
Blue Ridge Anesthesia Associates	17,461	0.2
Brajendra Misra	152,833	2.1
Center for Joint Surgery & Sports Medicine	1,667	0.0
Central ENT Clinic	339	0.0
Chesapeake Neurosurgery	4,291	0.1
Christopher Pellegrino	1,104	0.0
Delmarva Radiology, PA	15,061	0.2
Dominick Coletti	890	0.0
Drs Bird, Baumann & Assoc	1,050	0.0
Drs. Falik & Karim, PA	47,204	0.7
Emergency Services Associates	90,539	1.3
Enrique Daza	35,360	0.5
Figueroa & Ashker MDS, PA	16,294	0.2
First Colonies Anesthesia, LLC	28,890	0.4
Intensimed LLC	45,155	0.6
JHU, Clinical Practice Association	2,321,825	32.5
James C Todd III	1,930	0.0
James Gasho	7,178	0.1
James J Rascher, MD	5,277	0.1
James Robey	17,727	0.3
Jeffrey Muench	51,511	0.7
Joseph Ciacci	30,199	0.4
Kanu Patel MD PA	14,261	0.2
Konrad Dawson	23,743	0.3
Kurt E Wehberg	3,395	0.1
Mid-Atlantic Orthopaedic Specialists	11,677	0.2
Mohammad Khan	122,527	1.7
Montague Blundon, III	28,058	0.4
Montgomery Orthopaedics PA	7,460	0.1
Neurosurgical Specialists LLC	12,244	0.2
North American Partners-Maryland	9,839	0.1

PGHC Anesthesia Associates	**90,671**	**1.3**
Paul Olumuyiwa	**28,702**	**0.4**
Peninsula Neurosurgical Associates	**23,507**	**0.3**
Peninsula Orthopedic Associates, PA	**22,360**	**0.3**
Peninsula Pulmonary Associates, PA	**12,281**	**0.2**
Plastic Surgery of Cumberland	**3,271**	**0.1**
Rajindar S. Sidhu	**3,399**	**0.1**
Ramin Jebraili	**5,433**	**0.1**
Ricardo Pyfrom	**5,147**	**0.1**
Robert J. Carpenter	**3,523**	**0.1**
Sagar Nootheti	**13,684**	**0.2**
Said A Daee MD PA	**127,150**	**1.8**
Shock Trauma Associates, P.A.	**859,356**	**12.0**
Sinai Surgical Assoc	**119,185**	**1.7**
Sterling Anesthesia of Maryland	**6,191**	**0.1**
Sylvanus Oyogoa	**50,873**	**0.7**
Trauma Surgery Associates	**27,855**	**0.4**
Trauma Surgical Associates	**90,556**	**1.3**
UMOTO-HNS, P.A.	**3,997**	**0.1**
University of MD Ortho Trauma Associates	**448,191**	**6.3**
University of MD Eye Associates, PA	**667**	**0.0**
University of MD Orthopaedics Assoc., PA	**67,544**	**1.0**
University of MD Pathology Assoc., PA	**4,831**	**0.1**
University of MD Surgical Associates, PA	**28,647**	**0.4**
University of Maryland Anesthesia Associates, P.A.	**11,301**	**0.2**
University of Maryland Diagnostic Imaging Specialists, P.A.	**1,459,474**	**20.4**
University of Maryland Oral Maxial Surgical Associates	**81,426**	**1.1**
University of Maryland Physicians, P.A.	**23,117**	**0.3**
Vascular Surgery Associates	**7,205**	**0.1**
Victor Wowk	**25,516**	**0.4**
Vincent Casibang	**33,683**	**0.5**
Washington County Emergency Medicine Physicians	**8,998**	**0.1**
Washington County Hospital Trauma Physicians	**55,575**	**0.8**
Wendell Miles	**28,505**	**0.4**
William I Smith Jr, MD PC	**436**	**0.0**
Willie Blair	**64,141**	**0.9**
TOTAL	**$7,140,367**	**100.0%**

The total of $7,140,367 includes $198,660 in claims that were accrued but not paid in 2008 and $189,769 in recoveries from practices when other sources of payment existed.