

MARYLAND TRAUMA PHYSICIAN SERVICES FUND
Health General Article § 19-130

Operations from July 1, 2011 through June 30, 2012

Report to the

MARYLAND GENERAL ASSEMBLY

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This annual report on the Maryland Trauma Physicians Services Fund for fiscal year 2012 meets the reporting requirement set forth in Health General § 19-130(e) that directs the Maryland Health Care Commission and the Health Services Cost Review Commission to report annually to the Maryland General Assembly on the status of the Fund.

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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, Medicaid-enrolled patients, trauma-related on call and standby expenses, and trauma equipment grants. The Fund is financed through a \$5 surcharge on motor vehicle registrations and renewals.

Payments to eligible providers and the administrative costs associated with making those payments totaled about \$12,157,420 in FY 2012, an increase of approximately \$600,000 from FY 2011. Comparing FY 2012 to FY 2011, both uncompensated care payments and on call trauma payments increased by approximately \$100,000. Administrative costs rose in 2012 due to an increase in uncompensated claim volume. The Commission made trauma equipment grants to Level II and Level III trauma centers of \$42,857 each for a total of \$298,571. Transfers from the Motor Vehicle Administration (MVA) to the Fund increased by about \$100,000 in FY 2012.

The Maryland Health Care Commission (Commission) approved an 8 percent across the board reduction in payment rates for FY 2010 (with the exception of Medicaid) due to the downturn in automobile registration revenue and an expected increase in uncompensated care claims, which remained in effect in FY 2012.

The Commission informed the trauma community that higher on call payments for Level III trauma centers authorized by legislation passed in 2009 could not be implemented due to the disbursement limitation.¹

As a result of an audit of the Maryland Health Care Commission in 2011, the Office of Legislative Audits found that the Commission “did not require its contractor to confirm that trauma patients were listed on the Trauma Registry” and, therefore, not eligible for reimbursement of claims from physicians, in compliance with State law and its contract. MHCC has required the Trauma Fund’s third party administrator to reinstate the confirmation that all Trauma Fund patients are on the Trauma Registry. Commission staff has been diligent in analyzing whether Trauma Fund claims received by the Commission’s contractor for the period 2007 through 2011 were listed on the Maryland Trauma Registry retrospectively. The Commission is in the process of recouping all claims payments made for those patients not listed on the Registry.

MHCC projects that the Trauma Fund will face funding challenges through FY 2014. Implementation of the insurance coverage provisions of the Patient Protection and Affordable Care Act (ACA) in January 2014 should lead to reduced pressure on the Fund as a significant share of those currently uninsured will gain access to coverage. With nearly half of the 750,000 Maryland uninsured gaining access to coverage, uncompensated care payments should decline significantly beginning in FY 2015.

MHCC has identified several options that the Maryland General Assembly could enact that better balance spending and payments and tie more thoughtful policymaking into the payment reduction decision-making process. The options have been generally discussed with representatives in the trauma community. During the 2012 legislative session the Maryland General Assembly removed the restriction that expenditures from the Fund may not exceed the Fund’s revenues in a fiscal year, which will be effective on October 1, 2012.

¹ HB 521 (Maryland Trauma Physician Services Fund – Rural Trauma Centers - Reimbursement) permits the Level III Trauma Centers to receive stipends for on call up to 70,080 hours per year to maintain trauma surgeons, orthopedic surgeons, neurosurgeons, anesthesiologists, plastic, major vascular, oral or maxillofacial, and thoracic surgeons on call, effective October 1, 2009. If expected revenue in the Fund is insufficient to meet expected payments, the Commission may not reimburse Level III Trauma Centers for on call hours under this change for Trauma on call hours exceeding 35,040 until the remaining costs eligible for reimbursement for Level I, II, III, pediatric and specialty referral centers are fully funded.

Background

During the 2003 legislative session, the Maryland General Assembly enacted legislation creating the Maryland Trauma Physician Services Fund to aid Maryland’s trauma system by reimbursing trauma physicians² 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.³ The legislation directed the Health Services Cost Review Commission (HSCRC) to allow trauma center hospitals to include trauma-related standby expenses in HSCRC-approved hospital rates.

The legislation has been expanded several times since passage in 2003; expanding eligibility for Fund payments to other classes of trauma physicians and/or increased payment levels for classes of providers. These changes are summarized below in Table 1.

Table 1: Statutory Changes – 2006-2009
2006 – Expanded eligibility to uncompensated care and extended Medicaid reimbursement to physicians providing trauma. Increased on call payments to Level II and Level III Trauma Centers. Replaced the per specialty limit for on call hours with a per center limit on hours. Extended uncompensated care payments to include the Johns Hopkins Burn Center, Johns Hopkins Eye Trauma at the Wilmer Eye Institute, and the Hand Trauma Center at Union Memorial. Increased the ceiling on the stipend for Children’s National Medical Center to \$490,000. Awarded a one-time grant to Union Memorial Hand Center and trauma equipment grants to 7 Level II and Level III Centers.
2008 – Permitted the Level I Trauma Center, Pediatric Trauma Center, and 3 specialty referral centers to receive a limited on call stipends. Authorized physicians to receive uncompensated care payments for care provided at trauma center-affiliated rehabilitation hospitals. Raised the cap on uncompensated care reimbursement for emergency medicine physician practices. Increased the annual grant to Children’s National Medical Center to \$590,000. Permitted MHCC to award grants to Level II and Level III centers for trauma related equipment and systems from Fund balances. Permitted MHCC to adjust uncompensated care and on call rates.
2009 – Permitted Level III Trauma Centers to receive on call stipends for up to 70,080 hours per year to maintain trauma surgeons, orthopedic surgeons, neurosurgeons, anesthesiologists, plastic, major vascular, oral or maxillofacial, and thoracic surgeons. Gave MHCC authority not to reimburse Level III Trauma Centers for on call hours under this change for Trauma on call hours exceeding 35,040 until the remaining costs eligible for reimbursement for Level I, II, III, pediatric and specialty referral centers are fully funded.

Status of the Fund at the End of FY 2012

There has been little improvement, again, in Maryland’s economy during Fiscal Year 2012. The economic downturn and resulting job losses pushed more Maryland residents into the ranks of the uninsured over the past four years. Uncompensated care payments, Medicaid shortfall payments, and on call and standby stipends have increased, while revenue from automobile registrations and registration renewals remained relatively stable. The Commission approved an 8 percent reduction in Fund disbursements for FY 2010,

² COMAR 10.25.10 originally defined trauma physicians as trauma surgeons, anesthesiologists, orthopedic surgeons, neurosurgeons, critical care physicians, and emergency room physicians to conform to the statutory definition.

³On 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, though 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.

which began July 1, 2009, and remains in effect as of the writing of this report. The Commission is required to maintain solvency in the Fund under the law.

Collections by MVA via the \$5 surcharge were **\$11,683,370**, which were nearly \$100,000 higher than the \$11,584,887 collected in FY 2011, similar to the \$11,564,059 collected in 2010, and nearly \$700,000 less than the \$12.2 million collected in FY 2009. The Trauma Fund disbursed about **\$11,852,845** to trauma centers and trauma physician practices over the past fiscal year. Table 2 summarizes the revenue, disbursements, and the Fund balances at the end of FY's 2010, 2011, and 2012.

Table 2 - Trauma Fund Status on a Cash Flow Basis, FY's 2010-2012

CATEGORY	FY 2010	FY 2011	FY 2012
Fund Balance Start of FY	\$3,831,632	\$3,577,745	\$4,319,800
Collections from the \$5 Registration Fee (and interest)	\$11,564,059	\$11,584,887	\$11,683,370
Credit Recoveries	\$869,535	\$722,107	\$529,443
TOTAL FUNDS (Balance, Collections, Recoveries)	\$16,265,226	\$15,884,739	\$16,532,613
-- Uncompensated Care Payments	-5,183,510	-4,613,037	-\$4,794,732
-- On Call Expenses	-5,865,210	-5,883,212	-5,961,370
-- Medicaid Payments	-506,408	-267,249	-\$255,372
-- Children's National Medical Center Standby	-542,800	-542,800	-542,800
--Trauma Equipment Grants (disbursed from the surplus funds)	-199,997	0	-298,571
-- Administrative Expenses	-389,556	-258,641	-304,575
--Transfer to State's General Fund	-178,444	0	0
Total Expenditures	-\$12,687,481	-\$11,564,939	-12,157,420
TRAUMA FUND BALANCE, FY END	\$3,577,745	\$4,319,800	\$4,375,193

Outstanding Obligations for FY 2012

The Fund incurred outstanding obligations of approximately \$4.2 million, which are not reflected in the FY 2012 year-end balance in Table 2 above. These obligations result from applications for uncompensated care, Medicaid, on call, and standby expenses for services provided in FY 2012. As in past years, these obligations will be paid from the Fund's revenue collected by the MVA on registrations and renewals in the first three months of FY 2013.

Table 3 – FY 2012 Obligations Incurred after Year End
(Amounts Shown Reflect the Continuing 8 Percent Reduction Adopted by MHCC in July 2009)

Uncompensated Care claims	\$577,725
On call stipends	\$3,037,130
Children's National Medical Center FY 2012 Standby Expenses	\$542,800
Medicaid	\$ 35,988
TOTAL INCURRED BUT NOT PAID IN 2012	\$4,193,643

Payment to Practices for Uncompensated Trauma Care

During FY 2012, uncompensated trauma care services were reimbursed at 92 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 from FY 2010 through 2012.

Table 4 – FY 2012 Distribution of Uncompensated Care Payments by Trauma Center

Facility	% of Uncompensated Care Payments FY 2010	% of Uncompensated Care Payments FY 2011	% of Uncompensated Care Payments FY 2012
R. Adams Cowley Shock Trauma Center	31.84%	34.38%	52.84%
Johns Hopkins Hospital	15.57	15.58	15.47
Prince George's Hospital Center	19.37	19.45	15.7
Johns Hopkins Bayview Medical Center	7.17	7.49	3.89
Suburban Hospital	6.71	5.68	2.97
Peninsula Regional Medical Center	5.89	5.28	5.10
Sinai Hospital	4.4	3.0	0.96
Johns Hopkins Regional Burn Center	3.12	2.18	0.49
Washington County Hospital Center	2.64	2.33	1.40
Western Maryland Health System	1.07	0.73	0.35
Maryland Eye Trauma Center	1.59	1.32	0.53
Johns Hopkins Hospital Pediatric Center	0.63	0.37	0.13

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 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 payment, 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 and the federal government is 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
FY 2012**

Month	Amount Billed
June 2011 (billed in July)	\$24,263
July 2011	17,259
August 2011	22,990
September 2011	25,164
October 2011	19,117
November 2011	18,728
December 2011	20,945
January 2012	11,919
February 2012	16,203
March 2012	25,187
April 2012	28,823
May 2012	24,774
TOTAL	\$255,372

Payment for Trauma On Call Services

Hospitals reimburse physicians for taking call or serving on standby.⁴ On call and standby payments compensate physicians for foregoing work in a non-hospital setting where reimbursement may be higher and uncompensated care losses are lower. Payments for on call and standby are dependent on local market factors. Shortages of physicians practicing 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

⁴A 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.

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. Level II trauma centers may substitute a third year surgical resident for a trauma surgeon; and the trauma surgeon then must be on call.

On call expenses were reimbursed for the number of on call hours provided up to a maximum of 35,040 hours per year. FY 10 is the first year that the expanded on call stipends were reimbursed to the specialty trauma centers as a result of the statutory changes enacted in 2008. None of the centers reached the maximum payment ceilings allowable under the Fund in FYs 2009 and 2010 because some specialties operated on standby, a higher level of availability. Some physician contracts 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 for those hours. Several of the Level II trauma centers do not pay call for anesthesiologists for this reason. Other trauma center hospitals maintained orthopedic or neurosurgery availability without on call payments.

Table 6 – On call Payments to Trauma Centers, FY's 2010-2012

Trauma Center	FY 2010	FY 2011	FY 2012
Johns Hopkins Bayview Medical Center	\$718,361	\$749,465	\$743,795
Johns Hopkins Adult Level One			140,230
Prince George's Hospital Center	486,541	441,751	497,945
Sinai Hospital of Baltimore	622,543	703,008	695,702
Suburban Hospital	562,857	637,892	704,988
Peninsula Regional Medical Center	1,054,478	1,095,481	1,100,080
Meritus Medical Center (formerly Washington County Hospital Association)	958,354	939,441	962,912
Western Maryland Regional Medical Center (formerly Western Maryland Health System)	763,636	836,936	766,794
Johns Hopkins Adult Burn Center	118,502	68,462	70,116
Johns Hopkins Wilmer Eye Center	134,013	68,462	70,116
Johns Hopkins Pediatric Trauma	135,435	136,926	140,230
Union Memorial, Curtis National Hand Center	135,338	68,462	68,462
TOTAL	\$5,690,058	\$5,746,286	\$5,961,370

HSCRC Standby Expense Allocation

The HSCRC used the Reasonable Compensation Equivalent (RCE) developed by Medicare to set reasonable allowable standby cost ceilings.⁵ The actual costs per hour of standby were compared to these cost ceilings to include standby costs in the applicable hospital's rate base in FY 2005. Approximately \$4.1 million was included in FY 2005 rates for standby costs. Overall rates are updated each year (including these standby amounts) by applying the current year update factor to aggregate charges from the previous year. Table 7 presents the amount of applicable standby costs in each trauma center hospital's approved rates after the update factors have been applied.

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 a financial impact on the Fund because the expenses are incorporated into the hospitals' approved rates.

Table 7- Maryland Trauma Standby Costs in HSCRC-Approved Rates FY 2012

Trauma Center	Inpatient	Outpatient	Total
Johns Hopkins Hospital	\$1,027,065	\$154,748	\$1,181,812
Prince George's Hospital Center	1,973,358	56,303	2,029,661
Sinai Hospital	788,962	652,399	1,441,361
Suburban Hospital	518,878	214,737	733,753
Peninsula Regional Medical Center	-	-	-
Meritus Medical Center	642,654	313,514	956,169
Western Maryland Regional Medical Center	384,388	78,533	509,289
Total	\$5,335,305	\$1,470,234	\$6,852,045

Note: Peninsula Regional Medical Center reports no standby costs. Approximately \$4,127,800 in standby expense was included in FY 2005; the difference is due to the cumulation of HSCRC's annual updates for inpatient and outpatient services in FY's 2006-2011, including an update factor of 1.56% in FY 2012.

Payment to Children's National Medical Center for Standby Expense

The law allows the Fund to issue an annual grant of up to \$590,000 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 to \$490,000 as a result of changes at the close of the 2006 legislative session and another increase of \$100,000 as a result of legislative changes in 2008. Children's reported \$1,629,846 in standby expenses \$1,520,533 in FY 2012; FY 2011; \$1,550,187 in standby expenses in FY

⁵ The RCE limits are updated annually by CMS on the basis of updated economic index data. Notice is published in the *Federal Register*, setting forth the new limits. The RCE applicable to the various specialties is obtained from that notice. If the physician specialty is not identified in the table, the RCE is used for the total category in the table.

2010; approximately \$1 million in comparable standby expenses for FY 2009; and approximately \$1.1 million in standby expenses in FY 2008. The FY 2012 payment of \$542,800 (the annual stipend of \$590,000 minus the 8% Fund reduction) will appear in disbursements in FY 2013, as the application was received from CNMC in September 2012.

Trauma Equipment Grant Program

The Commission disbursed \$42,857 to each of the Level II and Level III trauma centers in FY 2012, for a total trauma equipment grants' expenditure of \$298,571 from the Trauma Fund surplus.

MHCC Administrative Expenses

The MHCC incurs personnel and contract costs associated with the administration of the Fund, though it has never sought reimbursement for those costs associated from the Fund. Approximately one FTE was dedicated to Fund activities in 2012, with most of the expense attributable to activities related to the administration of the Fund, including program and contract management. The MHCC incurs additional contractual expenses related to the administration of the Fund and these costs are charged to the Fund.

Audit Expenses

MHCC completed an RFP for audit services in FY 2009. The contract was awarded to Clifton Gunderson, LLP, to review the on call, standby, equipment grant, and uncompensated care applications submitted to the Fund. The Trauma Fund recovered \$100,000 as a result of the most recent audit findings conducted from July 2010 through June 2011. Clifton Gunderson is in the process of a third round of uncompensated care and on call audits since the award of the contract.

Administrative Costs: Use of a Third Party Administrator (TPA)

The MHCC contracts with CoreSource, Inc., with offices in White Marsh, Maryland, to provide claim adjudication services. MHCC awarded a five-year contract to CoreSource in December 2006 and modified in 2009. The contract funds will be spent somewhat ahead of schedule because claim volume has been higher than expected. At the request of Commission staff, CoreSource reduced its costs per claim at the end of 2009. The vendor began accepting electronic claims in ANSI 837 format in 2010. Wider use of electronic claims submission by practices in this narrow niche market will also lower costs to the vendor.

Revenue and Reimbursement Outlook

Table 8 presents estimated revenue (collections from the \$5 motor vehicle surcharge) and projected disbursements for 2012. The MHCC estimates that revenue from the MVA will increase modestly (3 percent) as the economy strengthens.

Growing uncompensated care payments are the single most important driver of higher payments in the program. Uncompensated care payments will continue to grow because the weak national economy will mean continued unemployment in the state, which translates to a higher number of uninsured. When these uninsured people suffer traumatic injuries, the physician portion of the costs of care provided at Maryland's trauma centers for those patients becomes the obligation of the Fund.

Other categories of disbursement covered by the Trauma Fund are capped by statute or will experience little growth. Most Maryland Trauma Centers are collecting close to the full amount of on-call payment for which

they are eligible. Since these payments are nearly at their maximum levels, on-call can increase only by the inflation adjustment MHCC uses to increase payments levels. MHCC projects Medicaid underpayment to remain stable over the next two years. The Maryland Patients' Access to Quality Health Care Act passed in the 2004 session required DHMH to raise physician fees under Medicaid to 80-100 percent of Medicare fees, if funds were available. Medicaid has decided to delay increased physician fee levels due to the current budget crisis. MHCC believes that trauma payments to make up the differences between Medicare and Medicaid will continue to be small.

MHCC expects to apply the 8 percent reduction in uncompensated care and on call payments that was first implemented in 2010 and continued in 2011 and 2012. The MHCC reluctantly adopted this reduction in 2009, effective in FY 2010, as payments would otherwise have exceeded the revenue collected. Although we expect revenue to increase in 2013, we expect payments to increase even faster, largely due to growing uncompensated care spending.

Additional on call obligations to Level III trauma centers, as permitted under the legislation passed in 2009, cannot be met given the current funding mechanism. The 2009 legislation allowed MHCC to meet the additional on-call obligations to Level III centers from current year funds after all other obligations have been met. MHCC does not expect to consider the new on-call payment requirements for Level III centers until FY 2015, when the spending outlook will improve.

MHCC projects that the Trauma Fund will continue to face funding challenges through FY 2014. Implementation of the insurance coverage provisions of the Patient Protection and Affordable Care Act (ACA) in January 2014 should lead to reduced pressure on the Fund as a significant share of those currently uninsured will gain access to coverage. With nearly half of the 750,000 uninsured gaining access to coverage, uncompensated care payments should decline significantly beginning in FY 2015.

Table 8 – Actual and Projected Trauma Fund Spending 2010-2013

	Actual FY 2010	Actual FY 2011	Actual FY 2012	Projected FY 2013
Carryover Balance from Previous Fiscal Year	\$3,831,632	\$3,577,745	\$4,319,800	\$4,375,193
Collections from the \$5 surcharge on automobile renewals	\$11,564,059	\$11,584,887	\$11,683,370	\$12,033,871
TOTAL BALANCE and COLLECTIONS	\$16,265,225	\$15,162,632	\$16,532,613	\$16,409,064
Total Funds Appropriated		\$11,700,000	\$12,200,000	\$12,200,000
Credits	\$869,535	\$722,107	\$529,443	\$700,000
Payments to Physicians for Uncompensated Care	(\$5,183,510)	(\$4,613,037)	(\$4,794,732)	(\$5,392,924)
Payments to Hospitals for On Call	(\$5,865,210)	(\$5,883,739)	(\$5,961,370)	(\$6,102,164)
Medicaid	(\$506,408)	(\$267,249)	(\$255,372)	(\$250,000)
Children’s National Medical Center	(\$542,800)	(\$542,800)	(\$542,800)	(\$542,800)
MHCC Administrative Expenses (TPA & Audit)	(\$507,366)	(\$258,641)	(\$304,575)	(\$310,000)
Trauma Grants (funding drawn from Fund Balance)		\$0	(\$300,000)	(\$300,000)
Transfers to the General Fund	\$178,444	\$0	\$0	\$0
PROJECTED YEAR-END BALANCE	\$3,577,631	\$4,319,273	\$4,375,193	\$4,211,176

Maintaining Reimbursement Levels and Fund Stability

The MHCC believes the stability of the Fund can be maintained over the next several years by using current authority to reduce payment levels. Although across the board spending cuts are politically easier to implement, continuing to reduce payments by 8 percent over the long run may not be the most effective approach to managing the Fund. It should be noted that consensus has been a key success factor in the trauma coalition’s campaign to establish financial support of the Maryland trauma care system. Under the current statute, MHCC has very limited authority to implement targeted reductions.

MHCC has identified several options that the Maryland General Assembly could enact that better balance spending and payments and tie more thoughtful policymaking into the payment reduction decision-making process. The options have been generally discussed with representatives in the trauma community. MHCC has recommended that the Maryland General Assembly remove the restriction that expenditures from the Fund may not exceed the Fund’s revenues in a fiscal year. The options are shown in Table 9, below.

Table 9 – Options for Modifying the Trauma Fund to Maintain Fund Stability

Option	Strengths/ Weaknesses
<p>1. Establish a clear priority for sequencing payments. Spells out a payment sequence. Under §§ 19-130 (d)(7)(i), the Commission may not reimburse Level III trauma centers for trauma on call hours under paragraph (4)(i)6 of this subsection or for trauma on call hours exceeding 35,040 hours until the remaining costs eligible for reimbursement under paragraph (4) of this subsection are fully funded. All other cost areas have equal priority. Further delineating priorities would be expanded to specify, for example, that uncompensated care be financed before on call payments were made.</p>	<p>Limited flexibility further delineates already defined priorities. Difficult for priorities to change, as importance is established in the statute.</p>
<p>2. Do not pay for certain types of trauma services, such as those that do not lead to a hospital admission. Historically, the Trauma Fund has reimbursed for any trauma-related service under the theory that physicians are eligible for uncompensated care any time the trauma team is activated and a patient is seen. Given the Fund shortfall, low severity cases limited to evaluations and consultations would not be covered. The financial burden of this change would fall heaviest on emergency medicine physicians, as that specialty is most frequently involved in the initial patient assessments.</p>	<p>Shifts the focus from providers to patients. Low intensity patients are not covered. Adds new incentives to the system at a time when system is undergoing change.</p>

Appendices

Appendix Table 1

**Maryland Motor Vehicle Registration Fees
Collections per Month, FY 2012**

Month	Total Revenue
Jul-11	1,010,697
Aug-11	1,135,851
Sep-11	1,026,552
Oct-11	932,438
Nov-11	860,053
Dec-11	813,149
Jan-12	871,480
Feb-12	898,583
Mar-12	1,034,605
Apr-12	1,007,482
May-12	1,060,173
Jun-12	1,032,307
Total	\$11,683,370

**Appendix Table 2
Uncompensated Care Payments in FY 2012,
Percent Paid by Practice**

Participating Practice	Percent of Claims Paid
Abdul Cheema	0.13
Adam Mecinski	0.62
Allegany Imaging, PC	0.22
Aminullah Amini	1.49
Anuradha Kulkarni	0.28
Bethesda Chevy Chase Orthopaedic Assoc., LLP	0.03
Bijan Bahmanyar	0.31
Brajendra Misra	0.83
Carlton Scroggins	0.4
Center for Joint Surgery and Sports Medicine	0.29
Center for Oral and Facial Reconstruction	0.03
David Whittaker	0.08
Delmarva Radiology, PA	2.49
Dimensions Healthcare Associates, Inc.	3.63
Drs. Falik & Karim, PA	0.32
Emergency Services Associates	2.29
First Colonies Anesthesia, LLC	0.53
JHU, Clinical Practice Association	20.56
Jeffrey Muench	0.67
Konrad Dawson	0.44
Meritus Physicians - Trauma	0.44
Mohammad Khan	0.92
Mohammad Naficy	0.23
Montague Blundon III	0.71
Neurosurgical Specialists LLC	0.09
Nia D Banks MD PhD LLC	0.48
North American Partners-Maryland	0.42
Ortho Trauma Bethesda	0.94
Paul Olumuyiwa	0.11
Peninsula Orthopedic Associates, PA	0.06
Said A Dae MD PA	1.89
Shock Trauma Associates, P.A.	24.58
Syed Ashruf	0.29
The Spine and Joint Center	0.19
Sylvanus Oyogoa	1.34
Trauma Surgery Associates	0.7
Trauma Surgical Associates	0.36
Univ of MD Diagnostic Imaging Specialists, P.A.	11.57

Participating Practice	Percent of Claims Paid
Univ of MD Eye Associates, PA	0.08
Univ of MD Oral Maxial Surgical Associates	1.15
Univ of MD Ortho Trauma Associates	14.28
Univ of MD Orthopaedics Assoc., PA	0.52
Univ of MD Pathology Assoc., PA	0.01
Univ of MD Physicians, P.A.	0.15
Univ of MD Surgical Associates, PA	0.69
Vascular Surgery Associates	0.21
Wendell Miles	0.57
Willie Blair	2.57
Yardmore Emergency Physicians	0.01
All	100.00