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

***Operations from July 1, 2012 through June 30, 2013***

***Report to the***

## MARYLAND GENERAL ASSEMBLY

**November 2013**


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*This annual report on the Maryland Trauma Physicians Services Fund for fiscal year 2013 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.*

This report was completed by the Commission's Administrative Center under the direction Bridget Zombro, Director of Administration. Karen Rezabek wrote the report. Brian Banschbach manages the revenue and expenditures for the Trauma Fund. For information on this report, please contact Karen Rezabek at 410-764-3259 or by email at karen.rezabek@maryland.gov.

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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 were about $11,643,380 in FY 2013, a decrease of more than $500,000 from FY 2012. Comparing FY 2013 to FY 2012, uncompensated care payments and on call trauma payments, combined, increased by approximately $395,000. Transfers from the Motor Vehicle Administration (MVA) to the Fund decreased by nearly $80,000 in FY 2013; while administrative costs were similar to those in FY 2012. Reimbursements to the Fund from physicians paid for uncompensated care claims from other sources were nearly $200,000 less in FY 2013 than 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 throughout FY 2013.

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 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 financial 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 by 2018, uncompensated care payments should decline slowly beginning in FY 2015.

MHCC has identified 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 became 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. This component of the law is no longer in effect as of September 30, 2013.

**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 physicians[2] 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 – 2006-2013 |
|---|
| 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. |
| 2012 – Removed the statutory restriction that expenditures from the Fund may not exceed the Fund's revenues in a fiscal year. |
| 2013 – Section 2, chs. 546 and 547, Acts 2009, (additional on call reimbursement for Level III trauma centers noted above) was abrogated and of no further force and effect as of the end of September, 2013. |

[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.

[3] 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, 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.

**Status of the Fund at the End of FY 2013**

Collections by MVA via the $5 surcharge were $11,609,441, which were nearly $80,000 less than the $11,683,370, collected in FY 2012; The Trauma Fund disbursed about $11,151,470 to trauma centers and trauma physician practices over the past fiscal year. Table 2, below, summarizes the revenue, disbursements, and the Fund balances at the end of fiscal years 2011, 2012, and 2013.

**Table 2 - Trauma Fund Status on a Cash Flow Basis, FY's 2011-2013**

| CATEGORY | FY 2011 | FY 2012 | FY 2013 |
|---|---|---|---|
| Fund Balance at Start of Fiscal Year | $3,577,745 | $4,319,800 | $4,375,193 |
| Collections from the $5 Registration Fee (and interest) | $11,584,887 | $11,683,370 | $11,609,441 |
| Credit Recoveries | $722,107 | $529,443 | $332,423 |
| TOTAL FUNDS (Balance, Collections, Recoveries) | $15,884,739 | $16,532,613 | $16,317,057 |
| -- Uncompensated Care Payments | -$4,613,037 | -$4,794,732 | -$4,834,368 |
| -- On Call Expenses | -$5,883,212 | -$5,961,370 | -$5,774,302 |
| -- Medicaid Payments | -$267,249 | -$255,372 | -$197,481 |
| -- Children's National Medical Center Standby | -$542,800 | -$542,800 | -$542,800 |
| --Trauma Equipment Grants (disbursed from the surplus funds) | $0 | -298,571 | $0 |
| -- Administrative Expenses | -$258,641 | -$304,575 | -$294,429 |
| Total Expenditures | -$11,564,939 | -$12,157,420 | -$11,643,380 |
| **TRAUMA FUND BALANCE, FY END** | **$4,319,800** | **$4,375,193** | **$4,673,677** |
| | | | |

In 2013, the overall economy improved in Maryland, but the Maryland Motor Vehicle Administration (MVA) reported collecting less revenue in FY 2013 than in FY 2012. MHCC has asked the MVA to provide further information on its collections. Given the slow growth in revenue from registrations, the Commission will

continue to apply an 8 percent reduction in Fund disbursements in FY 2014. These reductions started July 1, 2009 and are needed because the Commission is required to maintain solvency in the Fund.

**Outstanding Obligations for FY 2013**

The Fund incurred outstanding obligations of approximately $5.7 million, which are not reflected in the FY 2013 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 2013. As in past years, these obligations have been paid from the Fund's revenue collected by the MVA on registrations and renewals in the first three months of FY 2014.

**Table 3 – FY 2013 Obligations Incurred after Year End**
**(Amounts Shown Reflect the Continuing 8 Percent Reduction)**

| | |
|---|---|
| Uncompensated Care claims | $1,246,681 |
| On call stipends | $3,927,444 |
| Children's National Medical Center FY 2013 Standby Expenses | $542,800 |
| Medicaid | $18,356 |
| **TOTAL INCURRED BUT NOT PAID IN FY 2013** | **$5,736,281** |

**Payment to Practices for Uncompensated Trauma Care**

Table 4 presents the distribution of uncompensated care by the trauma center in which the care was provided for the fiscal years 2011 through 2013.

**Table 4 –Distribution of Uncompensated Care Payments by Trauma Center, FYs 2011-2013**

| Facility | % of Uncompensated Care Payments FY 2011 | % of Uncompensated Care Payments FY 2012 | % of Uncompensated Care Payments FY 2013 |
|---|---|---|---|
| R. Adams Cowley Shock Trauma Center and University practices | 34.38 | 52.84 | 49.48 |
| Johns Hopkins Hospital Adult Level 1 | 15.58 | 15.47 | 17.35 |
| Prince George's Hospital Center | 19.45 | 15.7 | 18.48 |
| Johns Hopkins Bayview Medical Center | 7.49 | 3.89 | 0.92 |
| Suburban Hospital | 5.68 | 2.97 | 4.79 |
| Peninsula Regional Medical Center | 5.28 | 5.10 | 3.17 |
| Sinai Hospital | 3.0 | 0.96 | 1.64 |
| Johns Hopkins Regional Burn Center | 2.18 | 0.49 | 0.24 |
| Meritus Medical Center (formerly Washington County Hospital) | 2.33 | 1.40 | 1.10 |
| Western Maryland Health System Memorial Trauma Center | 0.73 | 0.35 | 1.16 |
| Maryland Eye Trauma Center | 1.32 | 0.53 | 0.55 |
| Johns Hopkins Hospital Pediatric Center | 0.37 | 0.13 | 0.01 |
| Curtis National Hand Center | Not reported | Not reported | 1.11 |

During FY 2013, 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 confirm that the patient has no health insurance and directly bill the patient –applying its routine collection policies. 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 eligible for uncompensated care reimbursement. This requirement is consistent with the legislative intent, which made the Fund the payer of last resort for physicians providing trauma services.

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 eligible for payment, services must be provided at the trauma center or trauma center- affiliated rehabilitation hospital setting.

**Payment for Trauma On Call Services**

Hospitals reimburse physicians for being on call or standby. 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. 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. Hospitals negotiate on call and standby arrangements with physician practices that are essential to hospital operations. 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 physicians when they provide on call services, and certainly do so when

**Table 5 – On call Payments to Trauma Centers, FY's 2011-2013**

| Trauma Center | FY 2011 | FY 2012 | FY 2013 |
|---|---|---|---|
| Johns Hopkins Bayview Medical Center | $749,465 | $743,795 | $400,874* |
| Johns Hopkins Adult Level One | | 140,230 | 143,332 |
| Prince George's Hospital Center | 441,751 | 497,945 | 527,488 |
| Sinai Hospital of Baltimore | 703,008 | 695,702 | 635,068 |
| Suburban Hospital | 637,892 | 704,988 | 685,600 |
| Peninsula Regional Medical Center | 1,095,481 | 1,100,080 | 1,157,600 |
| Meritus Medical Center (formerly Washington County Hospital Association) | 939,441 | 962,912 | 987,005 |
| Western Maryland Regional Medical Center (formerly Western Maryland Health System) | 836,936 | 766,794 | 807,339 |
| Johns Hopkins Adult Burn Center | 68,462 | 70,116 | 71,666 |
| Johns Hopkins Wilmer Eye Center | 68,462 | 70,116 | 71,666 |
| Johns Hopkins Pediatric Trauma | 136,926 | 140,230 | $214,998* |
| Union Memorial, Curtis National Hand Center | 68,462 | 68,462 | 71,666 |
| **TOTAL** | **$5,746,286** | **$5,961,370** | **$5,774,302** |

* Bayview did not receive the on-call stipend for the second half of FY 2013 until August 2013. MHCC also requested a payment of $71,666 to Johns Hopkins Pediatric Trauma that was erroneously paid twice. These funds will be recovered when the On Call stipends are paid for the period July 1 through December 31, 2013.

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 are reimbursed for the number of on call hours provided up to a maximum of 35,040 hours per year. FY 2010 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.

**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 6 – FY 2013 Trauma Fund Payments to Medicaid**

| Month | Amount Billed |
|---|---|
| June 2012 (billed in July) | $35,988 |
| July 2012 | 14,661 |
| August 2012 | 11,784 |
| September 2012 | 21,488 |
| October 2012 | 16,748 |
| November 2012 | 13,976 |
| December 2012 | 12,693 |
| January 2013 | 13,855 |
| February 2013 | 22,508 |
| March 2013 | 15,589 |
| April 2013 | 10,430 |
| May 2013 | 7,760 |
| **TOTAL** | **$197,480** |

### HSCRC Standby Expense Allocation

The HSCRC used the Reasonable Compensation Equivalent (RCE) developed by Medicare to set reasonable allowable standby cost ceilings.[4] 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 2013**

| Trauma Center | Inpatient | Outpatient | Total |
|---|---|---|---|
| Johns Hopkins Hospital | $1,016,794 | $158,756 | $1,175,550 |
| Prince George's Hospital Center | 1,953,624 | 57,761 | 2,011,385 |
| Sinai Hospital | 781,072 | 669,296 | 1,450,368 |
| Suburban Hospital | 513,689 | 220,299 | 733,988 |
| Peninsula Regional Medical Center | - | - | - |
| Meritus Medical Center | 636,227 | 321,634 | 957,911 |
| Western Maryland Regional Medical Center | 380,544 | 80,567 | 461,111 |
| **Total** | **$5,281,950** | **$1,508,313** | **$ 6,790,263** |

*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 2006-2-13

### 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 pediatric 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 $1,632,240 in standby costs for Maryland pediatric patients in FY 2013; $1,520,533 in FY 2012; $1,629,846 in FY 2011; $1,550,187 in standby expenses in FY 2010; approximately $1 million in

[4] The RCE limits are updated annually by CMS on the basis of updated economic index data. Notice setting forth the new limits is published in the *Federal Register*. 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.

comparable standby expenses for FY 2009; and approximately $1.1 million in standby expenses in FY 2008. The FY 2013 payment of $542,800 (the annual stipend of $590,000 minus the 8% Fund reduction) will appear in disbursements in FY 2014, as the application was received from CNMC in August of 2013, following the close of the fiscal year.

**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. The Level II and Level III trauma centers reported expenditures of these funds to the Commission at the close of their 2013 fiscal year in July and August of calendar year 2013. The Level II and Level III trauma centers will be applying for the 2014-15 grants in the last quarter of calendar year 2013.

**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 2013, 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 for audit and third party administration services and these costs are charged to the Fund.

**Audit Expenses**

MHCC completed an RFP for MHCC audit services in FY 2013. The contract was awarded to Myers and Stauffer LC in January of 2013 to review the on call, standby, equipment grant, and uncompensated care applications submitted to the Fund. The Trauma Fund recovered $16,000 as a result of the most recent audit findings conducted from July 2011 through June 2012, though this audit cycle is not yet finalized.

**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, modified in 2009, and extended in 2012. The contract funds were spent somewhat ahead of schedule because claim volumes had 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 resulted in lower costs to the vendor. As of the writing of this report, the Commission expected responses to an RFP for claims adjudication services in early autumn and the award of a five-year contract for these services in late 2013.

**Revenue and Reimbursement Outlook**

Table 8 presents estimated revenue (collections from the $5 motor vehicle surcharge) and projected disbursements for 2014. The MHCC estimates that revenue from the MVA will increase modestly (3 percent).

Growing uncompensated care payments are the single most important driver of higher payments in the program. Changes in uncompensated care costs are related to changes in the number of people that are 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 the 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 from 80 to 100 percent of Medicare fees, if funds were available. Medicaid has decided to delay increased physician fee levels due to the status of the current budget. MHCC believes that trauma payments to make up the differences between Medicare and Medicaid will continue to be small.

MHCC expects to continue the 8 percent reduction in uncompensated care and on call payments until we see an increase in revenue or decrease in payments for uncompensated care. The Commission 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 slightly in 2014, we also expect payments to increase, largely due to growing uncompensated care spending.

**Table 8 – Actual and Projected Trauma Fund Spending for FYs 2011-2014**

| | Actual FY 2011 | Actual FY 2012 | Actual FY 2013 | Projected FY 2014 |
|---|---|---|---|---|
| Carryover Balance from Previous Fiscal Year | $3,577,745 | $4,319,800 | $4,375,193 | **$**4,673,677 |
| Collections from the $5 surcharge on automobile renewals | $11,584,887 | $11,683,370 | $11,609,441 | $11,650,000 |
| **TOTAL BALANCE and COLLECTIONS** | $15,162,632 | $16,532,613 | $15,984,634 | $16,323,677 |
| **Total Funds Appropriated** | $11,700,000 | $12,200,000 | $12,200,000 | $12,000,000 |
| **Credits** | $722,107 | $529,443 | $332,423 | $400,000 |
| Payments to Physicians for Uncompensated Care | ($4,613,037) | ($4,794,732) | ($4,834,368) | ($4,850,000) |
| Payments to Hospitals for On Call | ($5,883,739) | ($5,961,370) | ($5,774,302) | ($6,700,000) |
| **Medicaid** | ($267,249) | ($255,372) | ($197,481) | ($150,000) |
| Children's National Medical Center | ($542,800) | ($542,800) | ($542,800) | ($542,800) |
| MHCC Administrative Expenses (TPA & Audit) | ($258,641) | ($304,575) | ($294,429) | ($300,000) |
| Trauma Grants (funding drawn from Fund Balance) | $0 | ($300,000) | 0 | ($300,000) |
| Transfers to the General Fund | $0 | $0 | $0 | $0 |
| **PROJECTED FISCAL YEAR-END BALANCE** | $4,319,273 | $4,375,193 | $4,673.677 | $4,180,877 |

Additional on call obligations to Level III trauma centers, as permitted under the legislation passed in 2009, were not met given the current funding mechanism. The additional funding was not available during the four

years that this provision was in effect and, at the end of September 30, 2013, with no further action of the General Assembly, the requirement for additional funding was abrogated and of no further force and effect.

MHCC projects that the Trauma Fund's challenges in funding levels will begin to abate by FY 2015. 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 estimated 750,000 uninsured gaining access to coverage, uncompensated care payments should decline significantly beginning in FY 2015.

**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 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 and are set forth in Table 9, below.

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

| Option | Strengths/Weaknesses |
|---|---|
| 1. **Establish a clear priority for sequencing payments**. Spells out a payment sequence. Under §§ 19-130 (d)(7)(i), which is no longer in effect as of the writing of this report, 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. | Limited flexibility further delineates already defined priorities. Difficult for priorities to change, as importance is established in the statute. |
| 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. | 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. |

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|---|---|
| 3. **Establish a timeframe for eligibility of uncompensated care reimbursement.** Limit the look-back period for claims eligibility. Currently, MHCC does not limit the look-back period for uncompensated care trauma services. Recently, we identified claims for trauma services that were submitted more than five years after the initial trauma event. | Permits MIEMSS Trauma Registry validation to be restricted to a three year time horizon. |

# Appendices

## Appendix Table 1

### Maryland Motor Vehicle Registration Fees
### Collections per Month, FY 2013

| Month | Revenue |
|---|---|
| Jul-12 | $987,323 |
| Aug-12 | $1,059,250 |
| Sep-12 | $967,220 |
| Oct-12 | $939,447 |
| Nov-12 | $873,478 |
| Dec-12 | $818,611 |
| Jan-13 | $934,703 |
| Feb-13 | $851,808 |
| Mar-13 | $998,188 |
| Apr-13 | $1,003,512 |
| May-13 | $895,467 |
| Jun-13 | $1,280,434 |
| Total Revenue FY 2013 | $11,609,441 |

## Appendix Table 2
## Uncompensated Care Payments in FY 2013,
## Percent Paid by Practice

| Participating Practice | Percent of Claims Paid |
|---|---|
| Abdul Cheema | 0.21 |
| Adam Mecinski | 0.16 |
| Adam Schechner | 2.52 |
| Allegany Imaging, PC | 0.64 |
| Allegany Plastic Surgery | 0.33 |
| Aminullah Amini | 1.98 |
| Andrew Panagos | 0 |
| Anuradha Kulkarni | 0.21 |
| Bethesda Chevy Chase Orthopaedic Assoc., LLP | 0.01 |
| Bijan Bahmanyar | 1.66 |
| Brajendra Misra | 1.46 |
| Center for Oral and Facial Reconstruction | 0.05 |
| Community Surgical Practice LLC | 0.3 |
| David Whittaker | 0.12 |
| Delmarva Radiology, PA | 1.2 |
| Dimensions Healthcare Associates, Inc. | 0.94 |
| Drs. Falik & Karim, PA | 0.57 |
| Emergency Services Associates | 0.81 |
| First Colonies Anesthesia, LLC | 0.63 |
| JHU, Clinical Practice Association | 18.93 |
| Jacek Malik, Peninsula Regional Medical Center | 0.09 |
| Jeffrey Muench | 0.43 |
| Johns Hopkins Community Physicians | 0.93 |
| Kanwaljit Ahuja | 0.02 |
| Kenneth Means | 1.12 |
| Konrad Dawson | 0.62 |
| Larry Bryant | 0.96 |
| MEP LLC | 0.29 |
| Meritus Physicians - Trauma | 0.68 |
| Mid-Atlantic Orthopaedic Specialists | 0.03 |
| Mohammad Khan | 4.37 |
| Mohammad Naficy | 0.11 |
| Montague Blundon, III | 1.18 |

| Participating Practice | Percent of Claims Paid |
|---|---|
| North American Partners-Maryland | 0.31 |
| Ortho Trauma Bethesda | 0.72 |
| Peninsula Orthopedic Associates, PA | 0.19 |
| Revathy Murthy | 0.02 |
| Robert J. Carpenter | 0.1 |
| Robert Karp | 0.12 |
| Said A Daee MD PA | 1.1 |
| Shock Trauma Associates, P.A. | 16.33 |
| Syed Ashruf | 0.3 |
| Trauma Surgery Associates | 0.57 |
| Trauma Surgical Associates | 0.87 |
| UMOTO-HNS, P.A. | 0.06 |
| Univ of MD Anesthesia Associates, P.A. | 0.09 |
| Univ of MD Diagnostic Imaging Specialists, P.A. | 11.18 |
| Univ of MD Eye Associates, PA | 0.07 |
| Univ of MD Oral Maxial Surgical Associates | 1.3 |
| Univ of MD Ortho Trauma Associates | 19.73 |
| Univ of MD Orthopaedics Assoc., PA | 0.54 |
| Univ of MD Pathology Assoc., PA | 0.1 |
| Univ of MD Physicians, P.A. | 0.16 |
| Univ of MD Surgical Associates, PA | 0.22 |
| Vascular Surgery Associates | 0.1 |
| Wendell Miles | 0.1 |
| William I Smith Jr, MD PC | 0 |
| Willie Blair | 1.31 |
| Yardmore Emergency Physicians | 0.85 |
| All | 100 % |