Trauma Center Fund
Report
2017 Appropriation Act, Item 284

Use of Funds in Improving Virginia's Trauma System, and Review of Feasible

Long Term Financing Mechanisms and Potential Funding Sources for Virginia's Trauma Centers

October 1, 2017

Background

In 2006, Virginia's Trauma Center Fund was established in Section 18.2-270.01 of the *Code of Virginia (Code)*. The Trauma Center Fund collects fees associated with the reinstatement of driver's licenses and convictions for driving a motor vehicle under the influence of a substance or alcohol.

The 2017 Appropriation Act requires the State Health Commissioner to review current funding provided to trauma centers to offset uncompensated care losses, report on feasible long-term financing mechanisms, and examine and identify potential funding sources on the federal, state, and local levels that may be available to Virginia's trauma centers to support the system's capacity to provide quality trauma services to Virginia citizens.

Trauma System Funding Challenges

In 2004, a Joint Legislative Audit and Review Commission (JLARC) report "The Use and Financing of Trauma Centers in Virginia*"* stated that the Virginia trauma system faced financial burdens for two major reasons: uncompensated or undercompensated care and readiness costs. The JLARC study concluded that the 14 trauma centers in Virginia were losing a combined $44 million each year.

Trauma patients are those patients with severe, multisystem injuries that require complex critical care. Higher clinical care costs and trauma system readiness costs are not accounted for by public or private payers. Payment from these sources is limited to the provision of actual clinical care given to a patient with multiple isolated injuries. For example, a trauma patient with multiple serious injuries to his chest, abdomen and upper leg would be reimbursed for the treatment of three isolated injuries. This approach to reimbursement does not account for the physiological effects caused by multisystem trauma and the coordination of care that must occur.

Reimbursement rates also do not account for the specialized resources that must be maintained in a high state of readiness that may or may not be utilized. The cost of specialized training, extra staffing, surgical specialties that must be immediately available, and extra infrastructure required by trauma center designation must be absorbed by the facility. These costs are usually cross-subsidized by other initiatives or else trauma center services are eventually abandoned.

Use of Trauma Center Fund

The *Code* directs use of the Trauma Center Fund to defray the costs of providing emergency medical care to victims of automobile accidents attributable to alcohol or drug use. The amounts

of funds awarded are based on the trauma center's uncompensated costs to provide this emergency trauma care. Table 1 below summarizes the funding provided to each designated trauma center in CY16.

Table 1. Trauma Center Funding by Trauma Center

Trauma Center Name & Level of Designation	Total Funds Received for CY16
Level I Trauma Center Designation	
Inova Fairfax Hospital	**$1,442,391.29**
Carilion Roanoke Memorial Hospital	**$1,203,993.68**
Sentara Norfolk General Hospital	**$1,065,597.87**
UVA Health System	**$1,031,754.10**
VCU Health Systems	**$2,393,177.44**
Level II Trauma Center Designation	
Centra Lynchburg General Hospital	**$263,541.26**
Chippenham Medical Center	**$229,972.10**
Mary Washington Hospital	**$413,221.10**
Riverside Regional Medical Center	**$557,675.01**
Winchester Medical Center	**$307,287.68**
Level III Trauma Center Designation	
Carilion New River Valley Medical Center	**$111,930.81**
Johnston Willis Medical Center	**$106,155.65**
Lewis Gale Hospital - Montgomery	**$111,656.20**
Southside Regional Medical Center	**$127,616.95**
Virginia Beach General Hospital	**$422,849.14**
Total Funds Distributed	**$9,365,971.1**

Source: Office of Emergency Medical Services Staff

The level of readiness required of a trauma designated hospital is unparalleled by other disciplines. The Trauma Center Fund Disbursement Policy focuses on the readiness costs incurred by hospitals specifically due to being designated as a trauma center as illustrated in Table 2. The Virginia Department of Health's Office of Emergency Medical Services (VDH/OEMS) annually engages with the Trauma System Oversight and Management Committee of the State Emergency Medical Services Advisory Board to review the Trauma Center Fund Distribution Policy. Working with system stakeholders, the goal is to assure that utilization of funds remains relevant to current needs and addresses areas of deficiencies found during the trauma center designation process. This approach typically results in actual changes occurring triennially.

Table 2. Utilization of Trauma Funds by Category

Category	Total Funds Used	Percentage*
Support an administrative infrastructure	$4,187,516.69	43%
Support higher staffing levels	$3,199,591.73	33%
Support extensive trauma related training to staffs	$588,098.92	6%
Procure trauma specific patient care equipment	$468,345.02	5%
Support injury prevention/community outreach	$410,011.46	4%
Support a trauma specific comprehensive PI program	$269,406.78	3%
Support for outreach program(s)	$118,365.02	1.20%
Support for trauma related research	$9,339.95	0.10%
Renovation(s) of physical structures to benefit trauma care	$0.00	0%

*CY 2016 Expenditures were less than total trauma fund payments received
Source: Virginia Department of Health, Office of Emergency Medical Services Staff

Feasible Long Term Financing Mechanisms

VDH/OEMS has not identified any new sources of funding for Virginia's trauma system. The only source of funding dedicated to Virginia's trauma system continues to be the Trauma Center Fund. The recent Trauma System Consultation by the American College of Surgeons (ACS) Committee on Trauma noted that the Commonwealth of Virginia is very fortunate to have dedicated funding to support trauma centers, regional EMS councils and the state trauma system infrastructure. During their visit they noted that our trauma centers do not report the cost of care or charges associated with the care of injured patients and feel that this information would be valuable in demonstrating the need for trauma-readiness funding beyond what might be reimbursed by payers. The Trauma System Oversight and Management Committee has formed a taskforce to incorporate the recommendations put forth by the ACS into the State Trauma Plan, and the Data/Education workgroup is addressing this recommendation.

While Section 3505 (a) of the Affordable Care Act authorized the appropriation of $100 million to trauma centers and an additional $100 million to support state trauma systems for FY2010 through FY2015, funds were never appropriated to support the Section. Section 3505 came about through strong advocacy by state trauma system stakeholders and national associations. Section 3505 recognizes that hospitals designated as trauma centers incur additional costs due to both a higher ratio of uninsured or underinsured patients and the heightened level of resources required to be on call and immediately available in order to meet designation criteria.

VDH/OEMS continues to monitor the opportunities for other sources of funding to increase the support for Virginia's trauma system. Routine involvement with federal agencies and participation on the National Association of State Emergency Medical Services Officials' Trauma Managers Council allows OEMS to stay informed and supports efforts for identifying increased trauma funding sources.

While not a direct revenue source, the expansion of Medicaid could potentially help to offset the costs of uncompensated trauma care. According to a May 2017 brief from *The Commonwealth Fund* uncompensated care burdens fell sharply in expansion states between 2013 and 2015, from 3.9 percent to 2.3 percent of operating costs. Estimated savings across all hospitals in Medicaid expansion states totaled $6.2 billion. The largest reductions in uncompensated care were found for hospitals in expansion states that care for the highest proportion of low-income and uninsured patients. If the 19 states that chose not to expand Medicaid were to adopt expansion, their uncompensated care costs also would decrease by an estimated $6.2 billion (ACA Medicaid Expansion Hospital Uncompensated Care - The Commonwealth Fund).

In calendar year 2016 the Commonwealth's designated trauma centers provided care for 34,440 patients. Of those patients 2797, or 8.12% had Medicaid coverage and 4268, or 12.39% were recorded as self-pay patients. The Virginia State Trauma Registry does not currently collect cost of care data so we are unable to provide a financial impact analysis of Medicaid expansion at this time. However, if it were assumed that the 4268 self-pay patients met the eligibility qualifications set forth in the ACA expansion (nonelderly adults with incomes up to 138 percent of the federal poverty level - roughly $16,400 for an individual and $33,600 for a family of four in 2017), then it would be reasonable to expect that the potential gain to Virginia from increased Medicaid coverage would be significant.

Challenges to Current Funding

The Virginia Supreme Court Rule 1:24 became effective February 1, 2017 and is intended to facilitate the payment of fines, court costs, penalties and restitution assessed against those convicted of a criminal offense or traffic infraction. The rule requires the courts to make available deferred and installment payment plans to those individuals prior to suspending their driver's license for nonpayment.

The potential decline in driver's license suspensions will result in decreased collections of the $145.00 reinstatement fee, of which the Trauma Fund receives $100.00. The exact fiscal impact of Rule 1:24 is unknown at this time, however we do anticipate loss in funding.

Trauma system stakeholders are working with partner organizations such as the Virginia Hospital and Healthcare Association to assess the impact of this ruling and to seek alternate sources of ongoing funding.