Georgia Trauma Center Funding Methodology Review and Facilitation Proposal

FY 2027

July 20, 2026

GEORGIA TRAUMA COMMISSION

Georgia Trauma Center Funding Methodology Review and Facilitation

Proposed Workplan and Budget

Bishop+Associates

Project Purpose

Bishop+Associates (B+A) will assist the Georgia Trauma Commission (GTC) in reviewing, modernizing, and strengthening its trauma center funding methodologies, with particular attention to the Readiness and Uncompensated Care methodologies and the funding needs of Level III and Level IV trauma centers.

The project will be conducted with a Commission-appointed stakeholder workgroup and will focus on practical recommendations that are credible, understandable, data-informed, and capable of implementation.

Bishop+Associates brings extensive experience in trauma center finance, readiness cost analysis, uncompensated care methodology, and Level IV trauma center feasibility. Prior B+A Level IV work has included assessment of trauma patient volumes, revenue, costs, EMS and trauma center data, transfer patterns, payer mix, and the financial impact of trauma center designation.

Proposed Scope of Services

1. Facilitate Review of Existing Funding Methodologies

Bishop+Associates will work with Commission staff and the stakeholder workgroup to review the Commission's current Readiness and Uncompensated Care (UCC) funding methodologies, including the original methodologies developed by B+A.

Tasks

- Review current Readiness funding methodology.
- Review current Uncompensated Care funding methodology.
- Review historical methodology documents and prior analyses.
- Identify the original purpose and policy logic of each methodology.
- Assess whether the methodologies remain aligned with:
    - Today's Georgia trauma system.
    - Current trauma center roles.
    - Available data sources.

    - Commission funding objectives.
    - ACS verification expectations.
- Identify strengths of the existing methodologies.
- Identify limitations, vulnerabilities, and areas where the methodologies may now be outdated.
- Identify opportunities for simplification.
- Identify vulnerabilities and financial liabilities associated with Level III and Level IV trauma center designation.
- Facilitate workgroup discussion of guiding principles for future funding methodologies.

Deliverables

- Summary assessment of current Readiness and UCC methodologies.
- List of strengths, limitations, and simplification opportunities.
- Draft guiding principles for future funding methodologies.

2. Facilitate Evaluation of Funding Approaches for Level III and Level IV Trauma Centers

Bishop+Associates will work with the stakeholder workgroup to evaluate whether current funding methodologies appropriately support the role of Level III and Level IV trauma centers within Georgia's trauma system.

Tasks

- Review the unique role of Level III trauma centers in Georgia.
- Review the unique role of Level IV trauma centers in Georgia.
- Review information on Level III and IV trauma centers in other states (e.g., B+A South Carolina Level IV Trauma Center Study, Pennsylvania Trauma Systems Foundation).
- Assess current and historic trauma volume and transfer patterns.
- Consider Critical Access Hospital (CAH) and Rural Emergency Hospital (REH) designations and their financial implications.
- Review payer mix and UCC burden.
- Evaluate rurality, population characteristics, and regional access considerations.
- Identify operational and financial obligations associated with Level III and Level IV designation.
- Identify whether existing methodologies adequately recognize:
    - Readiness obligations.
    - Transfer responsibilities.
    - Low-volume access needs.

    - Rural coverage needs.
    - UCC exposure.
    - Designation-related costs and liabilities.
- Develop alternative funding approaches for Level III and Level IV centers.
- Evaluate whether distinct methodologies should be considered for Level III centers, Level IV centers, or both.

Potential Funding Approaches to Evaluate

- Base readiness/access payment.
- Volume-adjusted readiness payment.
- UCC-based funding component.
- Rural access adjustment.
- Critical Access Hospital or Rural Emergency Hospital adjustment.
- Transfer role adjustment.
- Hybrid methodology combining readiness, access, volume, and UCC factors.
- Separate Level III and Level IV methodology options.

Deliverables

- Level III/IV funding issues summary.
- Alternative funding approach matrix.
- Recommendation on whether distinct methodologies should be considered for Level III and/or Level IV trauma centers.

3. Facilitate Evaluation of Available Data Sources

Bishop+Associates will work with Commission staff and the stakeholder workgroup to review available data sources based upon previous projects, sample inquiries, and staff input that may inform future funding methodologies.

Tasks

- State trauma registry data.
- GQIP data.
- Georgia hospital discharge data.
- Payer mix information.
- Uncompensated care information.
- Readiness cost information previously collected by GTC.
- Identify data elements that are reliable and meaningful.
- Identify data elements that may be difficult to collect, inconsistent, or unnecessarily complex.

- Assess how available data could support Level III and Level IV funding decisions.
- Recommend data elements that provide meaningful policy guidance without creating unnecessary analytical complexity.

Work Product

- Data source review summary.
- Recommended data elements for future methodology use.
- Identification of data limitations and practical options for addressing them.

4. Facilitate Modernization of the Readiness Cost Methodology

Bishop+Associates will review the Commission's current Readiness Cost methodology with the stakeholder workgroup and evaluate opportunities to modernize the methodology using currently available data and practical analytical approaches.

Tasks

- Review current Readiness Cost methodology.
- Identify methodology components that remain valid.
- Identify methodology components that should be simplified, updated, or replaced.
- Assess consistency with applicable ACS verification and Georgia designation standards.
- Evaluate whether readiness costs should be treated differently by trauma center level.
- Consider how readiness funding should recognize:
    - Required trauma program infrastructure.
    - Medical staff availability.
    - Nursing and clinical readiness.
    - Call coverage expectations.
    - Registry, performance improvement, and administrative requirements.
    - Transfer and stabilization responsibilities.
    - Rural access and low-volume sustainability.
- Develop practical alternatives to the current Readiness Cost methodology.
- Compare alternatives based on fairness, simplicity, data availability, policy relevance, and ease of implementation.
- Apply alternative funding methodology options to current or historical funding data to estimate distributional impact by trauma center level, geography, rurality, volume, payer mix, and uncompensated care burden.

Work Product

- Readiness methodology modernization summary.
- Practical readiness funding alternatives.
- Recommended direction for updating the Readiness Cost methodology.

5. Stakeholder Facilitation and Consensus Building

Bishop+Associates will serve as an independent facilitator and subject matter expert throughout the engagement.

Tasks

- Plan stakeholder workgroup meetings.
- Prepare meeting agendas and discussion materials.
- Facilitate workgroup meetings and prepare meeting summaries.
- Guide discussion around funding principles and methodology options.
- Present alternative funding approaches.
- Evaluate advantages, disadvantages, and implementation considerations with the workgroup.
- Identify areas of agreement and unresolved issues requiring Commission direction.
- Build consensus around recommended funding principles and methodology options.
- Document workgroup discussions and recommendations.

Anticipated Meetings

- Kickoff meeting.
- Current methodology review meeting.
- Level III/IV funding issues meeting.
- Data source review meeting.
- Readiness methodology modernization meeting.
- Alternative funding options meeting.
- Draft recommendations meeting.
- Final workgroup review meeting.
- Presentation to the GTC Finance Committee.

Work Product

- Meeting agendas.
- Meeting materials.
- Meeting summaries.

- Consensus points and unresolved issue summaries.
- Workgroup recommendation summary.

6. Final Recommendations and Deliverables

Bishop+Associates will prepare recommendations for consideration by the GTC Finance Committee. B+A will assist Commission staff with methodology documentation, stakeholder communication, transition planning, and implementation steps after the Finance Committee reviews the final recommendations.

Tasks

- Synthesize findings from methodology review, data review, and stakeholder discussions.
- Prepare draft recommendations.
- Review draft recommendations with Commission staff.
- Reconvene the stakeholder workgroup to review and refine recommendations.
- Incorporate stakeholder feedback.
- Prepare final written report.
- Prepare presentation for the GTC Finance Committee.

Final Deliverables

- Summary of the stakeholder review process.
- Assessment of current Readiness and UCC funding methodologies.
- Recommended funding principles for Level III and Level IV trauma centers.
- Alternative funding methodology options.
- Advantages, disadvantages, and implementation considerations for each option.
- Recommendations regarding future data sources and analytical approaches.
- Final written report.
- Presentation summarizing the stakeholder workgroup's recommendations.

Project Timeline

Timeframe	Milestone
Late August 2026	Georgia Trauma Commission appoints stakeholder workgroup. Bishop+Associates conducts kickoff meeting to review project objectives, existing funding methodologies, historical analyses, and available data.

Timeframe	Milestone
September–December 2026	B+A facilitates stakeholder workgroup meetings to review current methodologies, evaluate available data sources, discuss funding principles, and develop alternative funding approaches for Level III and Level IV trauma centers.
January 2027	B+A synthesizes stakeholder input, develops draft recommendations, and reconvenes the workgroup to review, refine, and build consensus around proposed funding methodologies.
February 2027	B+A conducts final stakeholder meeting or meetings as needed, incorporates feedback, and prepares final recommendations.
By February 28, 2027	B+A submits final written report and presents stakeholder workgroup recommendations to the Georgia Trauma Commission Finance Committee for consideration.

Fee Estimate

Recommended Fixed Professional Fee

B+A proposes to complete the scope of services for a fixed professional fee of:

$150,000

This fee reflects the full professional effort required to review foundational trauma funding methodologies, facilitate a stakeholder process, evaluate Level III and Level IV funding issues, review available data sources, modernize the Readiness Cost methodology, develop alternative approaches, and prepare final recommendations for Commission consideration.

Budget by Scope Area

Scope Area	Fee
1. Review of existing Readiness and UCC funding methodologies	$21,600
2. Evaluation of Level III and Level IV funding approaches	$33,600
3. Evaluation of available data sources	$20,400
4. Modernization of Readiness Cost methodology	$28,800
5. Stakeholder facilitation and consensus building	$21,600
6. Final recommendations, report, and Finance Committee presentation	$24,000
Total Fixed Professional Fee	**$150,000**

Travel and Meeting Expenses

The fee assumes that all workgroup meetings will be conducted remotely. If the Commission requests an in-person meeting, travel expenses will be reimbursed at cost with prior approval.

Project Assumptions

This scope assumes:

- The Commission will appoint the stakeholder workgroup.
- Commission staff will coordinate workgroup participation.
- Commission staff will provide current funding methodology documents, prior analyses, funding history, and available data documentation.
- The project will rely primarily on existing available data.
- The scope does not include an independent audit of hospital cost reports or uncompensated care submissions.
- The scope does not include a full hospital-specific readiness cost survey unless added separately.
- All meetings will be conducted remotely unless the Commission requests in-person meetings.
- Final recommendations will be advisory to the Georgia Trauma Commission Finance Committee.

Optional Add-On Services

The following services can be added if the Commission desires optimum value from this project beyond the base scope.

1. Prepare Credible Norm-Based Cost Methodology for Payers

While the Georgia Trauma Commission developed the readiness cost tool for trauma fund payment purposes, the greater value is a credible trauma center tool for justifying their trauma patient response charge requests to payers.

The core issues are that the readiness cost tool does a poor job of drilling down to costs that are unreimbursed and the readiness cost tool is cumbersome for trauma center use. This project would produce a norm-based approach that would be credible with payers and simple for trauma centers to use.

A. Assess Trauma Hospital Accounting Treatment of Readiness Costs

Readiness costs ideally represent costs that are not allocated to trauma patients, the basic rationale for trauma patient response fees for payers. This component would survey Georgia TCs on their accounting systems treatment of readiness cost to determine how much is allocated to trauma patients. E.g., how much of in-house OR, neurosurgery call, etc. is allocated to trauma patients vs. spread among all patients. This would produce norms that could be easily applied by all trauma centers.

B. Prepare Simple Norm-Based Approach to Readiness Cost Estimates

The ultimate simplification of a readiness cost survey is to establish norms that trauma centers use instead of determining their own costs. E.g., a standard percent for senior administrator's time devoted to trauma; contracted physician call-based cost norm for employed physician specialist call.

C. Identify Readiness Cost Line Items Likely Including Reimbursed Costs

All readiness costs will be reviewed with input from trauma center financial and payer personnel to Identify readiness cost line items likely including reimbursed costs. Consideration will be given the amount of non-trauma patient emergency care provided by specialists and other issues impacting accuracy and credibility.

D. Produce Norm-Based Cost Methodology for Payers

This will involve additional information requests to financial and payer personnel. The product will be a norm-based tool for estimating readiness costs that is credible with payers that trauma centers would find simple to use.

Estimated Fee: $35,000

2. Level III/IV Readiness Cost Survey

This project will use Level III and IV trauma center readiness cost data collected from Georgia trauma centers and information from Bishop+ Associates on Level III and IV trauma centers. If additional information is needed for this project, a survey of Georgia Level III and/or IV trauma centers may be warranted. This component would develop and administer a focused survey for Level III and IV trauma centers to produce this information.

Estimated Fee: TBD

3. Prepare Data for Paper Production/Paper

Georgia has the unique opportunity to contribute nationally to trauma center viability in this Increasingly problematic time for hospital finance by Publishing the results.

A. Conduct Project in Manner That Optimizes Paper Production

   The project methodology will be designed to collect information and data in an organized manner that enables the efficient preparation of academic papers.

B. Produce Paper(s)

   One recommended paper to be led by Dennis Ashley, with a norm-based readiness cost methodology. There may be others.

Estimated Fee: TBD

ECONOMICS OF TRAUMA CARE IN 2026: EMERGING THREATS AND POTENTIAL SOLUTIONS

BISHOP+ASSOCIATES

IRVINE, CA

February 2026

www.traumacare.com

EXECUTIVE SUMMARY

In the 1990s, over 60 trauma centers closed due to high costs and poor reimbursement. In 1992, the Trauma Center Economic Study was conducted by Bishop+Associates (B+A), which defined the problem.

Trauma center financial realities began improving with the advent of trauma surcharges, payer contract carveouts, and state funding in poorer states. B+A proposed a trauma response surcharge to the Centers for Medicare & Medicaid Services (CMS), which it formalized in 2000. This normalized trauma payer contract carveouts on insured patients, resulting in high returns that covered most trauma readiness costs.

In 2010, the Affordable Care Act (ACA), which included major expansions in private health insurance and Medicaid, substantially reduced the number of uninsured patients, of which trauma centers received a disproportionate share.

Today, the economic challenges facing trauma centers are substantial:

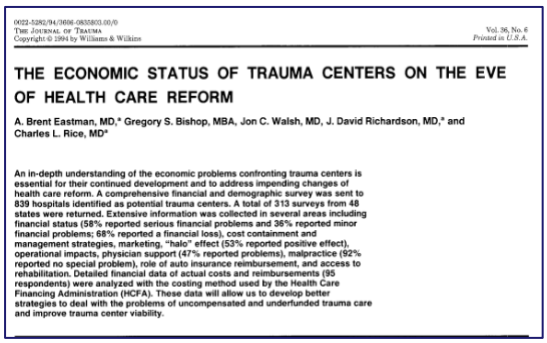
- Increased trauma center readiness requirements and costs
- Substantial increases in uninsured trauma patients
- Dramatic increase in poorly reimbursed geriatric patients
- Costly and problematic trauma medical staff structures
- Fallout from Office of Inspector General (OIG) report on trauma charges

Trauma centers face major financial risks and should develop strategies to ensure that they can continue providing essential trauma care to their communities. In this report, B+A explores the risks and proposes solutions.

WHAT IS CHANGING?

The First National Trauma Economic Study

In 1992, B+A developed the first trauma reimbursement profile, shown on the next page. The results were published in the Journal of Trauma, [which can be found on the B+A website].



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THE ECONOMIC STATUS OF TRAUMA CENTERS ON THE EVE OF HEALTH CARE REFORM

A. Brent Eastman, MD,* Gregory S. Bishop, MBA, Jon C. Walsh, MD, J. David Richardson, MD,* and Charles L. Rice, MD*

An in-depth understanding of the economic problems confronting trauma centers is essential for their continued development and to address impending changes of health care reform. A comprehensive financial and demographic survey was sent to 839 hospitals identified as potential trauma centers. A total of 313 surveys from 48 states were returned. Extensive information was collected in several areas including financial status (58% reported serious financial problems and 36% reported minor financial problems; 68% reported a financial loss), cost containment and management strategies, marketing, "halo" effect (53% reported positive effect), operational impacts, physician support (47% reported problems), malpractice (92% reported no special problem), role of auto insurance reimbursement, and access to rehabilitation. Detailed financial data of actual costs and reimbursements (95 respondents) were analyzed with the costing method used by the Health Care Financing Administration (HCFA). These data will allow us to develop better strategies to deal with the problems of uncompensated and underfunded trauma care and improve trauma center viability.

Trauma Payer Mix Has Shifted

In the 1990s, the primary mechanism of injury was motor vehicle crashes and almost 50% of all trauma patients were covered by private or auto insurance or workers compensation. Only 14% of trauma patients were covered by Medicare. Today, those numbers have flipped. Only 25% of trauma patients are privately insured and 50% of trauma patients are covered under poorly reimbursed Medicare.

Trauma Readiness Costs Have Soared

In 1992, the average cost of added medical staff support for trauma care was $800,000. By 2024, this cost is estimated at between $5-8 million per year (and rising) at a Level II trauma center.

High Payment by Privately Insured Trauma Patients Is at Risk

In 1992, the Cost Recovery Rate (CRR), revenue over patient treatment costs, was around 125% for patients with private health insurance (see following charts). For most trauma centers, the CRR was improved by the use of trauma response charges, and by 2024, Patient Cost Recovery Rate (PCRR) had risen to about 188%.

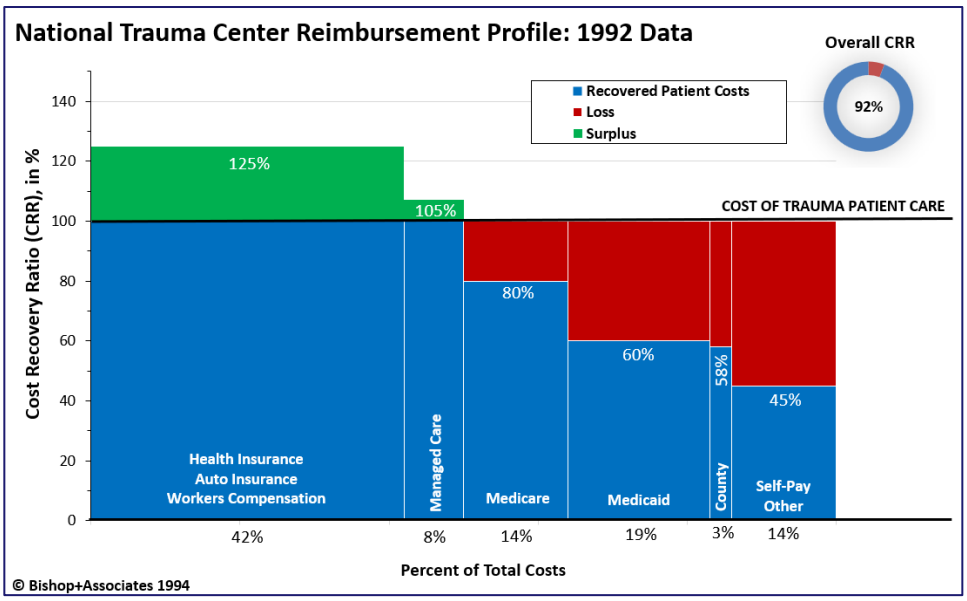
In 2025, the OIG issued a report highly critical of trauma response charges. This comes at a time of increasing cost pressures on payers, putting trauma centers at risk.

Cuts to ACA and Medicaid Will Increase the Number of Uninsured Patients

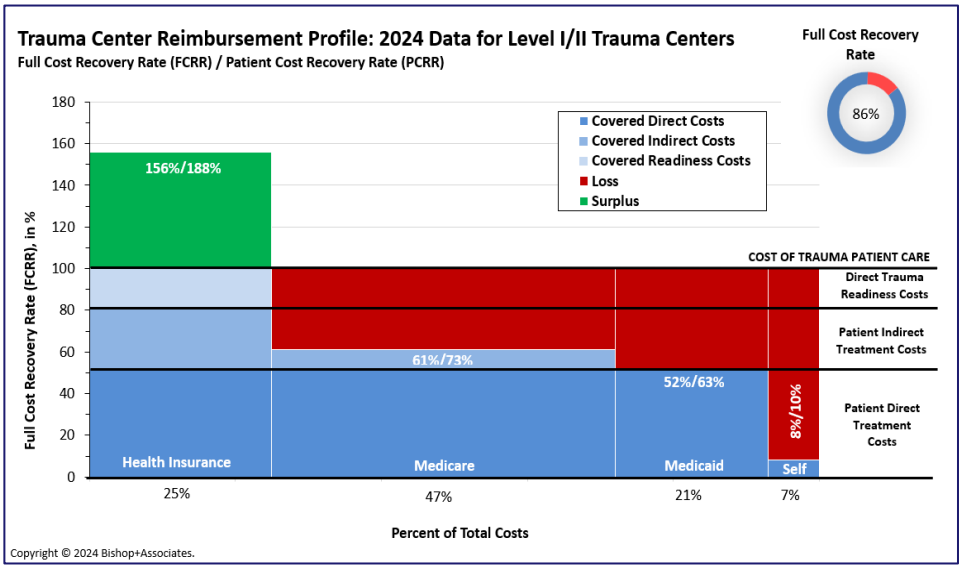
In 2004, 18% of trauma patients were uninsured. By 2024, due to ACA/Medicaid, this had dropped to <10% of trauma patients.

B+A REIMBURSEMENT PROFILES: 1992 vs 2024

This 1992 chart shows reimbursement by payer class. The cost recovery rate (CRR) is calculated as reimbursement divided by the **fully allocated patient treatment costs**. It does not include trauma readiness costs.



This 2024 chart shows the full cost recovery rate (FCRR), calculated as reimbursement divided by both **patient treatment costs and trauma readiness costs**. It also presents the patient cost recovery rate (PCRR), which only includes patient treatment costs.



Increased Trauma Center Readiness Requirements Come with High Costs

One the basic tenets of trauma care is a high level of constant readiness at trauma centers, especially Level I or Level II facilities. The American College of Surgeons (ACS) has substantially increased their requirements and readiness costs have risen substantially. They include:

- Costs associated with maintaining and staffing a trauma registry
- Performance improvement staffing requirements
- Increased facility requirements, such as a dedicated orthopedic operating room
- Rapid radiology (CT and MRI) response time requirements
- Rapid interventional radiology (IR) response time requirements
- Greater emphasis on injury prevention, disaster management, and prehospital education
- 24/7/365 trauma medical staffing in 23 specialties
- Departmental staffing on nights and weekends (OR, lab)

National studies estimate that it **costs hospitals a norm of $5 – 10 million per year** for Level I/II trauma center designation.

Facility and call coverage requirements pose a threat to many Level II facilities that struggle to maintain surgical subspecialty staffing. It is possible that some Level II trauma centers will be forced to downgrade to Level III trauma center status due to inability to meet the ACS Level II requirements.

Costly and Problematic Trauma Medical Staff Structures

For decades, one of the most significant economic threats to trauma centers has been escalating physician call pay, and about two-thirds of trauma readiness costs are attributable to medical staffing. This, matched with resident work hours restrictions and physician shortages in many specialties, only makes trauma care more demanding on its providers.

In 1994, total trauma center medical staff call pay was estimated at $800,000. Today, **the average cost for medical staff call pay at a Level I/II trauma center is between $5-10 million per year depending on the region of the country**. Trauma readiness costs related to medical staff have risen substantially due to:

- Increased ACS requirements, moving from 13 specialties (1994) to 23 specialties (2022) for Level I and Level II trauma centers
- Increased demand for higher payment by trauma specialists
- Increased demand for advanced practice provider (APP) support

For Trauma and Acute Care Surgery (TACS) and orthopedic hospitalists, reimbursement models are often based on call availability rather than work relative value units (wRVUs), resulting in poor productivity incentives. TACS models have become the norm at most trauma centers, with in-house general surgeons covering trauma care, surgical critical care, surgical hospitalist, and emergency general surgery call.

As trauma centers have adopted the TACS model, however, they added patient volumes that often exceed that of trauma patients, causing high patient censuses and hindering availability to respond to trauma activations. The extent of this problem is unknown, as trauma registries only capture trauma patients and the actual volume and workload of emergency general surgery is largely unquantified. Additionally, little is known about sub-specialty productivity because registries do not routinely track their responses.

Dramatic Increase in Poorly Reimbursed Geriatric Patients

Trauma field triage criteria, trauma center activation criteria, and trauma registry inclusion criteria have expanded dramatically in the past two decades to include more geriatric or Medicare patients. Falls are the leading cause of injury and the leading cause of injury-related death for adults ages 65 years and older.

In 1994, only 14% of trauma patients were covered by Medicare; today **Medicare patients comprise 50% of the payer mix at many trauma centers**. On average, Medicare's fixed reimbursement covers most of the direct patient treatment costs but only a portion of the indirect costs and none of the trauma readiness costs, so this payer class generates a substantial financial loss. As trauma centers expand to include more geriatric trauma patients, substantially more elderly patients are captured in the trauma registry, exacerbating this financial challenge.

This growing geriatric population presents a significant but often unrecognized opportunity for hospitals. By bringing Medicare patients into an organized system of trauma care, which emphasizes performance improvement and protocolized care, costs can be better managed, care can be standardized, and outcomes can be monitored and improved. From a financial perspective, lower lengths of stay in the Medicare population decrease overall patient treatment costs and increase the CRR.

Reductions in Health Care Coverage Will Increase Uninsured Population

The Affordable Care Act (ACA), enacted in 2014, expanded health insurance and reduced underinsurance for eligible Americans. In a study of patients with traumatic injury before and after the passage of ACA, Liu et al. (2020) found that the uninsured rate dropped from 22% to 15%, while Medicaid coverage increased from 17% to 25%.

Medicaid's low fixed reimbursement does not cover patient treatment costs, let alone trauma readiness costs, so it has always generated a substantial loss. It is predicted that the One Big Beautiful Bill (Public Law: 119-21, enacted 7/4/2025) will exacerbate this situation and have significant financial repercussions for trauma centers nationwide by reducing federal support for Medicaid and ACA programs and limiting eligibility for these benefits. **This will lead to increases in uninsured rates and uncompensated care burdens, lower reimbursements, reduced access to post-injury rehabilitation and home-based care, and increased strain on hospital finances.**

Safety net hospitals, or those hospitals that deliver care to the uninsured and other vulnerable populations regardless of a patient's ability to pay, are particularly at risk. Put another way, uncompensated care is significantly higher in trauma centers already considered highly financially vulnerable. If the proportion of uninsured trauma patients increases due to a reduction in Medicaid, it would be detrimental to the financial performance of trauma centers, especially in areas of the country with high Medicaid populations such as rural areas and dense urban areas. Such destabilization could lead to trauma center closures or reductions in services.

Office of Inspector General (OIG) Report on Trauma Charges Could Have Repercussions

In 2004, the Centers for Medicare & Medicaid Services (CMS) implemented the 068X trauma response charge, which allowed trauma centers to add a one-time charge for patients who received a trauma response and arrived at the hospital with prehospital notification. In the last two decades, there has been widespread adoption of trauma response charges, and when coupled with payer contract carve-outs, the 068X charge has drastically improved the financial viability of trauma centers.

In September 2025, the Office of Inspector General (OIG) released a report that negatively characterized trauma center use of these charges. Based on an audit of a small sample of such charges, OIG estimated that 77% of all claims submitted to Medicare with trauma team activations did not comply with federal requirements and that hospitals billed approximately $2.4 billion in unallowable charges for trauma team activations that did not meet Medicare requirements. While the findings only apply to Medicare patients, fallout from the report may lead to substantial reductions in revenue across all payers.

Trauma charges have received negative press over the years due to the varied and sometimes excessive amounts charged to patients with low severity injuries; the OIG report only adds to the negative perception of trauma response charges. Trauma program leaders often are not knowledgeable of the trauma charge process or actively audit trauma charge utilization. Hospital compliance officers may react to the OIG findings and challenge use of trauma response charges in general, not just for Medicare patients. More importantly, health plans that contract with hospitals operating trauma centers may also react by limiting eligibility or reducing the amounts paid.

RECOMMENDATIONS FOR HOSPITAL AND TRAUMA PROGRAM LEADERS

The opportunity to improve trauma center financial performance is significant, and trauma programs are uniquely positioned to identify, improve, and monitor opportunities for change that can improve the economic situation. In this section, we briefly highlight opportunities for trauma centers to improve patient care while also improving the trauma financial picture. Under these circumstances, trauma programs should take initiative.

1. Take Responsibility for Optimizing Trauma Response Charge Revenue

Trauma response charges are an important component of trauma center sustainability. However, given the spotlight on trauma charges due to the OIG report, trauma program leaders should take immediate steps to ensure their billing process is compliant with federal guidance on use of the 068x trauma charge. on our website. After completing such an audit, trauma program, payer liaisons, and revenue cycle managers should collaboratively optimize charges, payer contracts and charge processing with an efficient approach. **See the B+A Trauma Charge Audit Process on our web site.**

2. Take Responsibility for Managing Geriatric Costs

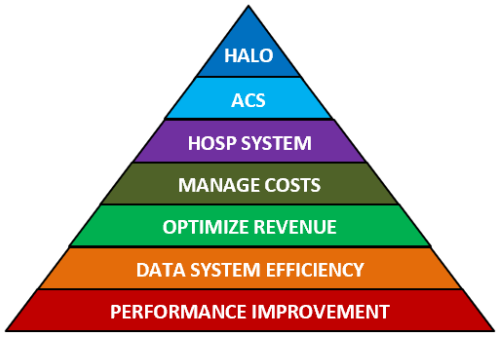
The development of an interdisciplinary Geriatric Fracture Program (GFP) can simultaneously lower costs and improve outcomes by streamlining care pathways and delivering significant cost savings. Given the low reimbursement from Medicare, this shift provides an opportunity to identify ways to reduce length of stay, decrease patient treatment costs, and improve financial performance. Trauma centers should identify and understand their geriatric trauma population, then leverage the unique capability of the trauma program to lead multidisciplinary collaboration among the many departments and specialties involved in the care of geriatric patients. Because Medicare reimburses at a fixed rate, any cost savings go directly to the bottom line.

RECOMMENDATIONS FOR TRAUMA CENTERS

3. Ensure Stable, Productive Trauma and Acute Care Surgery (TACS) Service
Most trauma centers in the United States have migrated to the TACS model. A strong TACS service is a leader in the hospital, but a weak service permeates medical staff culture, causes challenges with hospital leadership, and results in low productivity that does not cover costs. Trauma centers should benchmark the TACS roles, workload, costs, and professional fees to establish baseline data, then work with hospital leaders in a collaborative process to assess surgeon compensation, contracting, and scheduling.

4. Utilize the Trauma Registry for Enhanced Trauma Center Management
A trauma center invests heavily in data and can use its registry to meet enhanced trauma center and hospital capabilities that go beyond the core functions of data abstraction and performance improvement. Efficient software can reduce the tedious work for registry and PI staff, potentially resulting in program cost savings and new opportunities to optimize revenue and manage costs. Recent advances in Artificial Intelligence (AI) have improved the ability to accomplish numerous registry related tasks electronically, thereby decreasing costs (after the initial capital investment), saving time, and providing accurate and timely data.

B+A has adapted Maslow's hierarchy of human needs to provide a model for how trauma centers can use the registry to meet higher level trauma center and hospital needs that go beyond the core performance improvement function of the trauma registry.



TRAUMA REGISTRY HIERARCHY OF NEEDS

See the B+A Trauma Registry Hierarchy of Needs on our website.

RECOMMENDATIONS FOR TRAUMA CENTERS

5. Fully Evaluate Downgrading or Closing the Trauma Center

Trauma care is expensive, and some hospitals are in situations where they must consider if they can afford to continue offering trauma services. Administrators may be considering downgrading the hospital's level of trauma designation or closing the trauma program altogether. This could be due to a system merger that includes multiple trauma centers, because a facility cannot meet verification requirements for their current level, or because the financial picture is dire.

Decreasing the level of a trauma center or withdrawing a trauma center from the trauma system can have major impact on patients and the community. It also has financial, human resources, and emotional implications for a hospital.

B+A is equipped to work collaboratively with the hospital to assess alternatives for improving financial performance, the impacts of downgrade or closure, and all related issues. See Trauma Center Downgrade on our website.

6. Leverage the Trauma Center Halo Effect to Strengthen the Hospital

Trauma centers have unique multi-disciplinary collaborative capabilities that can be used to identify and implement solutions to hospital-wide challenges that go beyond trauma care. For example, optimizing geriatric trauma patient fracture care will improve outcomes and lower costs. The enhanced cost-conscious culture built for these patients will become embedded and extend to all geriatric patients similar to how trauma performance improvement proliferates throughout the hospital. Trama programs that take the initiative will achieve an enhanced stature within the hospital at a time of intense financial pressure.

CONCLUSION

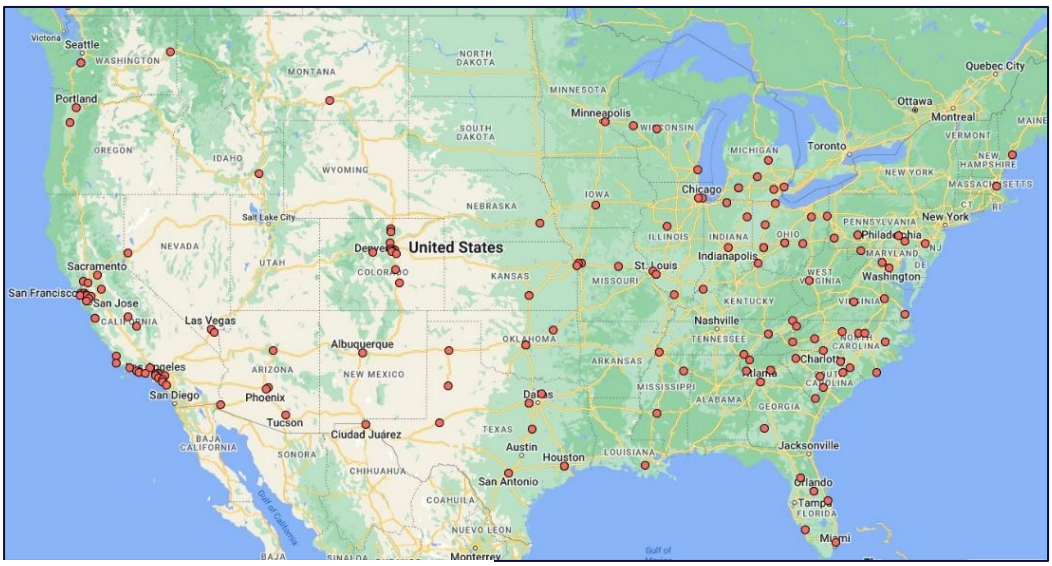
While trauma care is an essential component of public health, the economic sustainability of some trauma centers is at risk due to escalating costs, increasing numbers of un- and under-insured patients, potential restrictions on use of trauma charges, and declining reimbursement rates. However, strategic financial management, improved reimbursement structures, enhanced multidisciplinary collaboration, and cost containment initiatives can ensure the long-term viability of trauma care programs. Trauma centers and national trauma organizations must understand these challenges and identify ways to improve financial performance through innovative solutions.

Bishop+Associates (B+A) is proud to present *The Economics of Trauma Care: 2026,* which provides a historical context to trauma center finance by summarizing similar reports produced in 1994 and 2004, outlines the present-day challenges that threaten trauma centers, and identifies proactive solutions trauma centers can take to improve and secure their economic future.

Visit our website to download the
Trauma Center Economic Study 2026 Report

BISHOP+ASSOCIATES

Bishop+Associates (B+A) is committed to supporting trauma centers in addressing challenges and optimizing financial performance through innovative solutions. Since 1984, B+A has worked with over 300+ hospitals in 41 states to improve trauma center and trauma system development, finance, and management. B+A has played a pivotal role in advancing trauma care through national projects such as the **U.S. Trauma Center Economic Study**, the Trauma Resource Network, and the development of the **Trauma Center Association of America**. B+A also proposed the 68X trauma charge to the Centers for Medicare & Medicaid Services in 2000. All these efforts underscore Bishop+Associate's past and future commitment to improving trauma care and ensuring the financial sustainability of trauma centers across the nation.



Bishop+Associate Clients

We are uniquely qualified to assist hospital and trauma program leaders in handling the challenges they face. Trauma centers facing serious financial obstacles are encouraged to contact Bishop+Associates to discuss possible consulting services that address those challenges.

Visit our website at **www.traumacare.com**.