WISCONSIN HOSPITAL ASSOCIATION

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5510 Research Park Drive, Ste. 200
Fitchburg, WI 53711
608.274.1820 | FAX 608.274.8554
www.wha.org

September 23, 2026

Margaret Wogahn
State Trauma Coordinator
Division of Public Health
Wisconsin Department of Health Services
201 E Washington Ave
Madison, WI 53707

DELIVERED ELECTRONICALLY

Re: Request for Public Comments on the Economic Impact of Proposed Rule for Scope Statement 046-25, Relating to Trauma Care

Dear Ms. Wogahn,

The Wisconsin Department of Health Services ("DHS") has requested public comments on the economic impact of its proposed revisions to Wisconsin Administrative Code Chapter DHS 118 that would update the criteria for hospitals to be classified as level III and IV trauma care facilities ("TCFs"), pursuant to Scope Statement 046-25. The Wisconsin Hospital Association ("WHA") appreciates the opportunity to comment, and we offer the following limited comments in the context of DHS's preparation of an economic impact analysis. We look forward to continuing to work with DHS on a Wisconsin trauma classification system that supports local access to trauma care. We intend to provide full comment upon formal publication of the proposed rule and its accompanying notice for public hearing in the Administrative Register.

WHA was pleased to accept the invitation by DHS to participate in the DHS Chapter 118 Administrative Rule Advisory Committee. We also support the department's goal of revising the Trauma Chapter in a way that advances trauma care and fosters participation in Wisconsin's Trauma Care Program activities. We recall the last lengthy and difficult process, from 2015 to 2019, and then implementing, in 2021, the DHS 118 trauma criteria currently in place for Level 3 and Level 4 trauma designation. Throughout the prior review WHA and our members shared with DHS the obstacles that some of the requirements would pose and the consequence if these obstacles were not mitigated.

We have now experienced the impact of these obstacles on participation in the state's voluntary trauma facility designation program. For example, increased orthopedic call coverage requirements in

the 2019 update are unattainable for many rural hospitals, and can even harm physician recruitment and retention efforts and the service availability so vital to an aging rural Wisconsin population. This single change created a necessity to seek a lower-level designation, or to forgo designation entirely, for several hospitals in Wisconsin. Surveyor insistence on designated hours for trauma leaders, coordinators, and data registrars, and the meeting and training requirements for busy staff and physicians, have resulted in even more hospitals choosing to not seek or maintain Level III or Level IV trauma classification.

In our acceptance of a seat at the table for the DHS Chapter 118 Advisory Committee we asked that DHS remember that impact on care, quality and access must be viewed not just through the lens of national recommendations, such as the American College of Surgeons "Resources for the Optimal Care of the Injured Patient", but also with a view to the benefit, burden and attainability for Wisconsin facilities and health care professionals providing care across the state. By providing more flexibility in equipment requirements, allowing a broader pathway to maintaining classification while addressing survey findings, and reducing required hours of education for busy health care professionals needed at the bedside, DHS is incorporating this view into the proposed chapter, and that is appreciated. But even with more flexibility and the committee's goal to consider attainability in the review, the economic impact of seeking Level III and Level IV Trauma Classification is not minor.

WHA's comment on the economic impact of the draft Chapter 118 revision is limited to those activities that are predominantly or solely undertaken to achieve trauma classification. Hospitals have robust staffing and patient care plans, emergency department protocols, onboarding processes, ongoing education and training, and standing committees for quality improvement, peer review, medical staff governance, administration and nursing to be continuously prepared to deal with all types of patients, including injured patients. For many of the Level III and Level IV criteria, hospitals carry out the work whether they seek classification or not.

WHA assessed several areas as having an economic impact, including, but not limited to, 1) hours that must be dedicated to the trauma program, including the trauma program manager ("TPM"), the trauma medical director ("TMD"), the trauma registrar, and required attendance at the trauma peer review committee and the trauma multidisciplinary operations committee; 2) the time and cost of renewing Advanced Trauma Life Support ("ATLS") for groups that the hospital or medical staff would only require to be completed at least once; and 3) the work required to develop and maintain the numerous written documents required.

The dollars hospitals could spend on the first item alone, described in Criterion 1.1 and 1.2, illustrate the considerable annual and ongoing economic impact this rule draft will have on each hospital that seeks trauma classification. We provide our estimates of cost as information useful to DHS as they assess the economic impact.

Criterion	Level	Description	Type
1.1	III and IV	A TCF's institutional governing body, hospital leadership, and medical staff shall demonstrate continuous commitment and provide the necessary human and physical resources to properly administer trauma care consistent with the level of classification with written resolutions reaffirmed every three years, signed and dated within one year of classification site visit.	Type 1
1.2	III and IV	A TCF shall identify trauma professionals and dedicated hours necessary to adequately administer a trauma program consistent with the TCF's level of classification and trauma patient volumes.	Type 2

Each eight hours dedicated to trauma during a two-week pay period (0.1 fte) for a TMD, a TPM and a trauma registrar, using the midpoint for salary and fringe benefits calculated from the WHA Information Center Guide to Wisconsin Hospitals for a Wisconsin hospital staff member, and the midpoint salary and fringe benefits from the American College of Emergency Physicians, will cost the hospital an estimated $136,800 annually. Add in the cost of the salaries and fringe to meet the required attendance levels at the trauma multidisciplinary peer review committee and the multidisciplinary systems or operations committee, and assuming a baseline of 12 two-hour meetings a year, and the hospital is spending a total of $180,176 a year.[1,2,3] Using an estimate of 120 Wisconsin hospitals eligible to seek Level III or Level IV Trauma classification, the criteria for dedicated hours and trauma meeting attendance alone could add $21,621,120 in expense for Wisconsin's small and medium-sized medical surgical hospitals. Factor in maintaining ATLS certification, required education, and developing and maintaining the required documentation, and the economic impact will be much higher.

DHS noted in their April 16, 2019 Economic Impact Analysis of Proposed Rule for Scope Statement 112-15, Relating to Trauma Care, the last revision of DHS Chapter 118:

"Although there is a cost to meet the proposed new requirements of this rule, there is also a significant financial benefit. Per the Department of Health and Human Services, Centers for Medicare and Medicaid Services, only hospitals that are either classified as trauma centers by their state or local governing body that has the authority to do so or are verified by the ACS are able to bill for a trauma team activation fee. Each hospital/trauma center is able to set their own rate for this fee which can vary from $1,000 to $20,000+ per patient. Due to this, the estimated potential total revenue for trauma centers/hospitals each year is significantly greater than the potential estimated implentation and compliance costs."

WHA agrees that the reimbursement trauma-classified hospitals may receive could mitigate the economic impact somewhat, but we respectfully disagree that the estimated total revenue will exceed the cost of trauma classification. Hospitals can set their own rate, but insurance companies are not required to pay for trauma care and often do not. In addition, the state's aggregate number does not acknowledge that especially small rural hospitals must meet the same criteria, with the same associated costs, but have fewer trauma activations so do not have the opportunity to bill for these very often. Finally, adding costs to health care must be taken very seriously; unnecessary expense creates unnecessary burden on patients, hospitals and their communities.

Thank you for the opportunity to provide our analysis and comments. WHA appreciates that the DHS 118 draft is far less prescriptive than the current criteria. That will be helpful. We would also appreciate an eye to implementation, and a balanced approach to the need to "show your work". Perhaps there is an opportunity to reduce some of the written requirements in this iteration of DHS Chapter 118. Beyond the dollars and cents required to staff these requirements, the compliance burden of "showing your work" creates additional administrative costs and burden for already heavily regulated hospitals. A report by the American Hospital Association finds that an average-sized hospital dedicates 59 full-time employees to regulatory compliance and that more than 25 percent of these employees are doctors and nurses, making their expertise unavailable to patients.[4]

Wisconsin hospitals and health systems, and their partners in state government, have a great tradition of collaborating to advance policies that will help strengthen health care, and this support has an impact. As WHA noted in a recent press release, Wisconsin hospitals continue to rank among the nation's best in quality. This demonstrates the commitment hospitals have to the patients and communities they serve and is an economic advantage to other industries across the state who depend on high-quality healthcare for employees and their families.

We look forward to providing our full comments when the proposed rule is published and noticed for hearing in the Administrative Register, and to supporting requirements that are feasible and sustainable, especially in vulnerable urban and rural settings and amidst the demographic, workforce and financial challenges facing Wisconsin hospitals and health systems.

Sincerely,

Ann Zenk, RN BSN MHA
Senior Vice President Workforce and Clinical Practice
Wisconsin Hospital Association

Cc: DHS Secretary Kirsten Johnson
DHS State Health Officer and Administrator for the Division of Public Health Paula Tran

[1] Wisconsin Hospital Association. Fiscal Year 2024 Guide to Wisconsin Hospitals. October 2025.
[2] ACEP Now. The 2025 Physician Compensation Report. [Online] August 2025. https://www.acepnow.com/article/the-2025-emergency-physician-compensation-report/
[3] Doximity. Physician Compensation Report 2026. [Online] https://www.doximity.com/reports/physician-compensation-report/2026 accessed September 23, 2026.
[4] U.S. Ways and Means Committee. Medicare Red Tape Relief Project. [Online] June 2018. https:// waysandmeansforms.house.gov/uploadedfiles/red_tape_relief_final_-_v4.pdf.