WISCONSIN HOSPITAL ASSOCIATION
ADVOCATE. ADVANCE. LEAD.

***Please Extend Critical Health Care Programs*** to continue important innovations in care and sustain the viability of rural "tweener" hospitals:

- **Telehealth**
- **Hospital at Home**
- **Medicare-Dependent & Low-Volume Adjustment**

**WHA Ask:**
***Please work to ensure these important programs are extended without using pay-fors that would financially endanger fragile hospitals and health systems.***


**WHA Staff Contact**
Jon Hoelter
VP Federal & State Relations
jhoelter@wha.org


*February 2025*

# Extensions Needed to Critical Health Care Programs

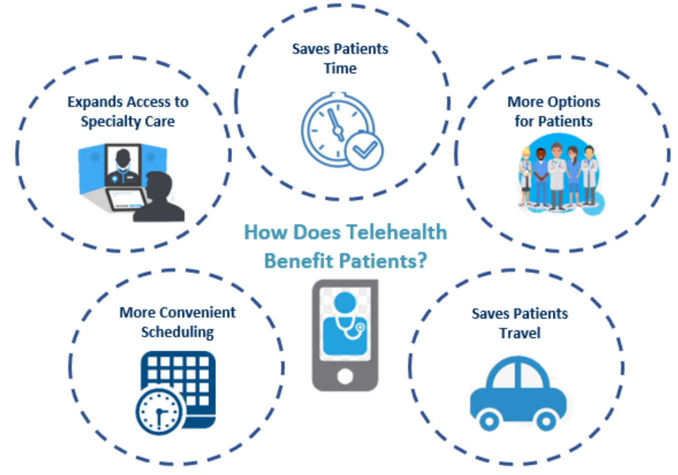
## Programs Set to Expire at End of March 2025


### Summary

Congress must act by the end of March to preserve innovations in care, such as telehealth and the Hospital at Home program, and to allow rural "tweener" hospitals to stay afloat.


### Preserving Telehealth Gains – Geographic and Site Restrictions; Audio Only

Prior to waivers granted during the COVID-19 pandemic, Medicare had geographic and site restrictions. This means it only reimbursed for telehealth care provided to patients located in rural, health professional shortage areas (geographic) who traveled to a health care facility (site) to receive telehealth. The COVID waivers have unleashed the potential of telehealth which has expanded availability of services and led to more convenient care options for patients and practitioners alike.




Additionally, Medicare has continued to allow audio-only telehealth services for Medicare patients who are either uncomfortable using video applications or are unable due to poor internet coverage.

### Preserving the Hospital at Home Program

CMS began a program called "Acute Hospital Care at Home" during the COVID pandemic. This innovative program allows patients to receive an inpatient level of care in the comfort of their own home for approved services and has been tremendously popular.

Hospital at Home is a rare "win-win" proposition. Not only do patients prefer treatment at home (with some studies showing reduced complications and shorter lengths of stay), but the program also frees up physical space at hospitals to expand room for patients with higher-acuity needs. Additionally, initial studies have shown either savings or at least net-neutral cost to the Medicare program. There are currently five Wisconsin-based health systems approved for this program (with a sixth expected shortly) as well as six other approved systems based in other states that also have a Wisconsin presence.

### Care Innovations Critical for Addressing Workforce Shortages

Telehealth and Hospital at Home are key in assisting hospitals combat workforce shortages. Hospitals are currently utilizing telehealth to extend specialty care to more remote areas of the state and to staff essential services like hospitalists and ICUs when other providers are unavailable, often during late-night shifts.

WISCONSIN STATE JOURNAL

Great Lakes without ice

LOCAL&STATE, A3

REGULAR SEASON CLOSES

Wisconsin traveled to No. 3 Purdue on Sunday in hopes of raising its postseason seeding

SPORTS, B1

The Oscars
Coverage inside A8

Pier for Gaza coast

U.S. Army vessel carrying

NATION&WORLD, A8

WHERE YOUR STORY LIVES

HEALTH CARE | WISCONSIN WORKFORCE SHORTAGE

1 in 10 hospital jobs unfilled

Report warns that hospitals need help in reversing trend

Similarly, the Hospital at Home program helps hospitals free up onsite staff for higher-acuity care by serving approved lower-acuity patients in their own homes with trained home-based care providers working in tandem with hospital staff to treat episodes such as infections, respiratory, circulatory, and kidney care with the same level of care of an inpatient stay.

### Protecting "Tweener" Hospitals by Extending Medicare-Dependent and Low-Volume Hospital Programs

Congress established the Medicare-Dependent Hospital (MDH) program in 1987, allowing hospitals with 100 or fewer beds that serve a high proportion of Medicare patients to receive slightly enhanced reimbursements compared to the normal payment rate larger hospitals receive under the Centers for Medicare and Medicare Services (CMS) prospective payment system. These payments allow MDHs greater financial stability and leave them better able to serve their communities.

Similarly, Congress established the Low-Volume Hospital adjustment (LVH) in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 in response to a report from the Medicare Payment Advisory Commission (MedPAC) that warned about a widening gap between rural and urban hospital profitability. Congress expanded the program in 2010 and reauthorized it again in the Bipartisan Budget Act of 2018. The LVH program gives rural hospitals with low volumes between a 0-25% payment boost on a sliding scale based on their low volumes.

***Unfortunately, both programs are set to expire at the end of 2024 and must be reauthorized by Congress to avoid serious cuts for Wisconsin hospitals***.

| WI 10-year Impact of Losing MDH & LVH Designations | | |
|---|---|---|
| **Congressional District** | **# Hospitals Impacted** | **Est. Annual Impact** |
| Bryan Steil | 2 | -$65.3 million |
| Mark Pocan | 3 | -$35.8 million |
| Derrick Van Orden | 2 | -$23.0 million |
| Scott Fitzgerald | 3 | -$43.9 million |
| Glenn Grothman | 4 | -$41.7 million |
| Tom Tiffany | 2 | -$18.4 million |
| **Statewide** | **16** | **-$228.1 million** |
| *Source: AHA Analysis of 2025 IPPS Rule* | | |

### The MDH and LVH Programs Help Hospitals Offset Losses from Medicare and Medicaid

Most rural hospitals in Wisconsin operate with fewer than 25 inpatient beds as critical access hospitals (CAHs) and are eligible to receive close to break-even rates from Medicare. However, rural hospitals above that threshold or that were otherwise ineligible for the CAH program when it began would receive the normal prospective payment rate that larger hospitals receive, which amounts to about 73% of the cost to provide care in Wisconsin. For this reason, we sometimes refer to these hospitals as "tweeners," as they are generally too big to be CAHs but also too small to have the volume of patients normal PPS hospitals need to offset Medicare and Medicaid losses – they are somewhere in-between. ***Losing MDH or LVH status would make it extremely difficult for them to operate since they do not have the same volumes of privately insured patients to offset losses from Medicare and Medicaid.***

### Medicare Underpayments are a Growing Problem for Wisconsin Hospitals

Because Wisconsin is an aging state, it is seeing a large shift in people moving off private insurance and onto Medicare. In fact, as of 2022, Wisconsin was tied for 11th among states with the highest percentage of their population covered by Medicare, at 21%. Due to this, a**nnual Medicare underpayments to Wisconsin hospitals have grown from $1.77 billion in 2016 to $3.3 billion in 2022, an 86% increase in 6 years.** This problem can be particularly challenging for rural areas which tend to have a higher percentage of their population at a Medicare eligible age.

### 10 Year Impact of Losing MDH/LVH Combined with Proposed Site-Neutral Cuts = $5 Billion Cut to WI Hospitals

Despite some groups arguing that rural hospitals have not been targeted by site-neutral payment cuts, many site-neutral cuts on the table would apply to these tweener hospitals since they are paid under the PPS system. The Cassidy/Hassan framework would attempt to offset some of the impacts with additional safety-net hospital "reinvestments," but it is unclear what the overall impact would be. ***The prospect of losing MDH status combined with site-neutral payment cuts would be a devastating one-two punch for these hospitals, many of which are already operating at either negative or extremely thin margins. For this reason, it is critical that Congress does not attempt to fund extensions of these important health care programs using hospital site-neutral payment cuts as pay-fors.***

| Congressional District | Site-Neutral 10-year Impact |
|---|---|
| Bryan Steil | -$635 million |
| Mark Pocan | -$718 million |
| Derrick Van Orden | -$1.1 billion |
| Gwen Moore | -$793 million |
| Scott Fitzgerald | -$385 million |
| Glenn Grothman | -$520 million |
| Tom Tiffany | -$273 million |
| Tony Wied | -$425 million |
| **Statewide** | **-$4.78 Billion** |