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December 19, 2024

The Honorable Ron Johnson
United States Senate
Washington, DC 20515

The Honorable Tammy Baldwin
United States Senate
Washington, DC 20515

The Honorable Gwen Moore
U.S. House of Representatives
Washington, DC 20515

The Honorable Mark Pocan
U.S. House of Representatives
Washington, DC 20515

The Honorable Glenn Grothman
U.S. House of Representatives
Washington, DC 20515

The Honorable Bryan Steil
U.S. House of Representatives
Washington, DC 20515

The Honorable Tom Tiffany
U.S. House of Representatives
Washington, DC 20515

The Honorable Scott Fitzgerald
U.S. House of Representatives
Washington, DC 20515

The Honorable Derrick Van Orden
U.S. House of Representatives
Washington, DC 20515

The Honorable Tony Wied
U.S. House of Representatives
Washington, DC 20515

Dear Members of Wisconsin's Congressional Delegation:

Thank you for meeting with WHA last week to discuss crucial extensions needed for federal health care programs before the end of the year, as well as important priorities we hope Congress will consider as part of a year-end package. While WHA is supportive of many of the health care provisions that were in the spending package unveiled late on December 17, we understand the current situation to fund these and many other federal items is fluid. ***While WHA supports long-term extensions for the health care items highlighted below, what is most important is that Congress finds a way to extend them before they expire.***

Telehealth

Prior to the COVID-19 waivers, Medicare's geographic and site restrictions only allowed reimbursement for telehealth care provided to patients in rural, health professional shortage areas (geographic) who traveled to a health care facility (site) to receive care. These waivers have unleashed the potential of telehealth which has expanded services and led to more convenient care options for patients and practitioners alike.

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. ***WHA strongly supported the 2-year extension included in the CR spending package but urges Congress to act quickly, whether on a short-term or long-term extension. Failure to do so is likely to result in canceled patient telehealth appointments due to the uncertainty over Medicare's coverage.***

Hospital at Home

Similar to telehealth, 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.

The *Hospital at Home* program 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. Hospitals can then treat these patients with lower-acuity needs in the comfort of 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 at the same level of care of an inpatient stay. Additionally, initial studies have shown either savings or at least net-neutral cost to the Medicare program. There are currently six Wisconsin-based health systems approved for this program as well as six other approved systems based in other states that also have a Wisconsin presence. ***WHA strongly supported the 5-year extension for this program included in the CR health care extensions, which would help provide more certainty to additional hospitals and health systems looking to grow this program. However, like telehealth, it is important that Congress act sooner rather than later to extend this program or patients will have to be disenrolled due to its impending expiration at year's end.***

Medicare-Dependent and Low-Volume 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		

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 a slightly enhanced reimbursement compared to the normal payment rate larger hospitals receive under the Centers for Medicare and Medicare Services (CMS) prospective payment system.

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.

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 would receive the normal prospective payment rate that larger hospitals receive which amounts to about 74% 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 rural CAHs but also too small to have the volume of patients normal PPS hospitals have to offset Medicare and Medicare 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. WHA supported the 1-year extension included in CR package, but again reiterates the need for at least a short-term extension to these programs before year's end.***

National Provider Identifier for HOPDs

WHA was pleased that no site-neutral payment cuts were included in the CR health care package, however, we were disappointed to see the provision requiring off-campus hospital outpatient departments (HOPDs) to obtain new national provider identifiers (NPIs), which would add to the administrative burden of health care providers with no public policy benefit and a dubious Congressional Budget Office (CB0) score. ***We strongly urge Congress to keep this proposal out of any future spending packages.***

As WHA has previously communicated, off-campus HOPDs are already required to report a billing type that indicates they are an HOPD as well as a modifier that indicates they are off campus. Additionally, claims must include an address that matches the location they are billing from. For this reason, there appears to be little to no rational policy benefit to requiring these locations to now obtain a new NPI.

Health care providers are already swimming in federal regulations, unnecessary paperwork, and labyrinthian prior authorization policies and this will only add to the administrative burden. Furthermore, the Congressional Budget Office's score of $2.4B savings over the budget window appears to be more an exercise in "wish casting" that CMS will catch more inaccurate claims and insurers will adopt more policies that deny payments for facility fees (an option CBO admits insurers already have), will then lower premiums to consumers instead of capturing these savings in their profit margins, and finally pass the savings onto the government in the form of reduced employer health insurance tax deductions.

Passing the *Improving Seniors Timely Access to Care Act*

Beyond extending critical programs that are poised to expire at the end of 2024, Congress also has considered important reforms to prior authorization, which negatively impacts millions of Americans by delaying their care or making them or their health care providers responsible for paying bills that should have been paid by their insurance. The U.S. Department of Health and Human Services Office of Inspector General has put out a number of troubling findings about how commercial Medicare Advantage plans have used prior authorization to unfairly deny care to Medicare beneficiaries despite them meeting Medicare coverage rules. The same OIG also found that Medicare Advantage plans ultimately approved 75% of requests they originally denied, calling into question the scale and reason for denials.

While CMS has tried to improve prior authorization in Medicare Advantage via rulemaking, the *Improving Seniors Timely Access to Care Act* would codify many of these reforms and strengthen federal law by:

- Reducing the administrative burden on clinicians by establishing standardized electronic prior authorization processes directly through a provider's electronic health records system.
- Increasing transparency around Medicare Advantage prior authorization requirements including timeframes on approvals, expedited approval processes, and real-time decisions for routinely approved items.
- Requiring health insurance plans to report on approvals, denials (including the use of artificial intelligence to deny), and denials that are ultimately overturned.
- Creating additional protections for enrollees based on historical prior authorization data.

WHA urges Congress to work to quickly pass this legislation which enjoys wide bipartisan support.

Protecting 340B

Hospitals continue to suffer from the actions of drug companies denying 340B prescription drug discounts at community pharmacies that contract with hospitals, significantly increasing the costs of these drugs hospitals

purchase. Despite both the first Trump Administration and successive Biden Administration taking the position through HRSA, which oversees the 340B program, that these actions are illegal, drug companies have successfully blocked HRSA's enforcement via litigation, protecting their immense profits at the expense of 340B hospitals and community health centers. These actions by drug companies have increased drug costs for the average 340B Critical Access Hospital by more than $500K annually, as well as more than $3M annually for the average Disproportionate Share 340B hospital.

Furthermore, certain pharmacy benefit managers (PBMs) have instituted discriminatory reimbursement policies to essentially pocket the savings Congress intended for 340B hospitals and other 340B covered entities by reimbursing them at lower, below-market rates for prescription drugs solely because of their 340B status.

To address these harmful actions, a gang of six bipartisan senators led by Senator John Thune (and which includes Wisconsin Senator Tammy Baldwin) introduced draft legislation entitled the Sustain 340B Act, legislation that would strengthen the 340B federal statute to prevent drug companies and PBMs from engaging in these practices that undermine the intent of the 340B program.

WHA urges Congress to promptly take up this legislation in the next Congress to help restore the intent of the 340B prescription drug program and help hospitals that are struggling to operate due to continued skyrocketing drug costs.

Long-Term Solutions Needed to Sustain High Quality Health Care

2024 was a difficult year for Wisconsin health care. Up until early 2024, Wisconsin had gone more than a decade without a hospital closure. The closure of two hospitals, HSHS Sacred Heart in Eau Claire and St. Joseph's in Chippewa Falls, shows just how challenging it is to sustain safety net services as losses from Medicaid and Medicare continue to mount for hospitals.

Unfortunately, the challenges faced by these hospitals are not isolated examples. In fact, ***one-third of Wisconsin's hospitals had a negative operating margin in 2023, and about one-half (82) hospitals had a lower operating margin in 2023 compared to 2022, a troubling trend.*** In addition to the two hospital closures previously mentioned, several other hospitals and health systems grappled with difficult decisions to end service lines, such as labor and delivery, and close primary care clinics that serve their communities.

Wisconsin's aging demographics mean this challenge is only likely to get worse. In fact, as of 2022, Wisconsin was tied for 11th among states with the highest percentage of their population covered by Medicare, at 21%. This dynamic means that ***Wisconsin hospitals are likely to continue seeing dwindling revenues due to aging demographics and the reality that hospitals lose money as patients transition from commercial market rates to Medicare rates that pay less than it costs hospitals to provide such care.*** This illustrates the need for long-term solutions that allow health care to adapt to these growing challenges.

Please contact your leadership to stress the importance of Congress acting quickly to extend funding for telehealth, the Hospital at Home program, and Medicare-Dependent and Low-Volume hospital designations. Additionally, we look forward to working with you in the next session of Congress on long-term extensions to these programs, as well as solutions to the 340B program and prior authorization.

Sincerely,

Eric Borgerding
President & CEO