WISCONSIN HOSPITAL ASSOCIATION

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October 1, 2025

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 and RWHC members in early September to discuss crucial extensions needed for federal health care programs before the end of the fiscal year as well as the impending expiration of enhanced health insurance premium subsidies at the end of the year. As you know, WHA has been concerned about the impact a federal government shutdown will have on health care providers primarily in the areas of:

- Telehealth
- The Hospital at Home Program
- Medicare Dependent and Low-Volume Hospitals

While we greatly appreciate the past bipartisan support for all three of these federal health care programs, patients and providers have been negatively impacted by the effects of a government shutdown on these programs. ***We ask that you work together to quickly end this shutdown and work with the Trump Administration to minimize any impacts on health care providers and patients.***

Telehealth

Prior to the waivers granted during the COVID-19 pandemic, Medicare's geographic and site restrictions meant that it generally only reimbursed for telehealth provided when a patient was treated at a health care facility

located in a rural, health professional shortage area. While Congress has acted to permanently remove geographic and site restrictions for behavioral health and substance use treatment, they remain for general fee-for-service Medicare telehealth services absent the extension of the COVID-19 waivers which expired on September 30.

This means no telehealth-to-home services will be covered for traditional Medicare patients during a shutdown, nor will care provided via telehealth when a patient is at a health care facility outside of a rural health professional shortage area. Audio-only services would also no longer be allowable. And, even behavioral health and substance use treatment will resume confusing requirements for in-person evaluations prior to telehealth treatment absent an extension of waivers. To add even more confusion for patients and providers, telehealth claims for patients covered under Medicare Advantage plans may continue to be paid, as would claims from providers billing from certain accountable care organizations (ACOs).

Telehealth waivers have been a key tool for assisting hospitals in combating workforce shortages. In addition to extending services directly to patients' homes, 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 that are notoriously difficult to staff.

On October 1, CMS issued limited telehealth guidance implying that telehealth providers may choose to continue providing telehealth waiver services while Medicare Audit Contractors hold fee-for-service claims for up to 10 days. CMS indicated they believe this would have a minimal impact on providers since the earliest electronic claims may be paid is 14 days after they are filed. However, Congress would have to include retroactive funding in a subsequent CR for such claims to be covered, or hospitals could choose to send Medicare beneficiaries an Advanced Beneficiary Notice of Noncoverage. Unfortunately, neither option is ideal, and some Wisconsin providers have already indicated to WHA they are temporarily pausing these telehealth services due to this uncertainty.

We encourage Congress to act swiftly to end this shutdown with retroactive telehealth coverage. The longer the shutdown lasts the more uncertainty providers and patients will have about whether their telehealth services have been covered. Congress should also establish a more uniform, permanent telehealth policy to bring clarity to the confusing nature of the current patchwork quilt of telehealth waivers that largely depend on whether a patient is in traditional Medicare versus Medicare Advantage or whether or not providers participate in Accountable Care Organizations.

Hospital at Home

Like telehealth, the Hospital at Home program has been a key tool in assisting hospitals navigating workforce shortages. The program has even helped hospitals free up onsite staff for higher-acuity care by serving approved 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.

The Wisconsin hospitals participating in Hospital at Home are extremely proud of their programs. Each of them poured significant resources into setting up and designing their programs in order to obtain the appropriate waivers from CMS. Patients have reported extremely high satisfaction scores with the program, and more and more studies are showing the safety and efficacy of the program.

Unfortunately, CMS previously issued guidance directing all hospitals with active Acute Hospital Care at Home waivers to discharge or return to the hospital all inpatients by September 30, 2025. ***The uncertainty caused by the shutdown for Hospital at Home programs illustrates the need for Congress to authorize it permanently to prevent future disruptions for patients and clinicians each time a CR is scheduled to end.***

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 CMS prospective payment system. These payments allow MDHs greater financial stability and leave them better able to serve their communities.

WI 10-year Impact of Losing MDH & LVH Designations		
Congressional District	**# Hospitals Impacted**	**Est. Annual Impact**
Bryan Steil	2	-$64.7 million
Mark Pocan	3	-$29.4 million
Derrick Van Orden	2	-$18.3 million
Scott Fitzgerald	3	-$36.9 million
Glenn Grothman	4	-$40.7 million
Tom Tiffany	2	-$16.9 million
Tony Wied	1	-$11.7 million
Statewide	**17**	**-$218.6 million**
Source: AHA Analysis of 2026 IPPS Rule		

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.

These programs are lifelines for the 17 rural Wisconsin hospitals that qualify for them, and it is critical that Congress includes retroactive funding for these programs to ensure these hospitals do not lose funding for any care delivered under Medicare during this shutdown.

Enhanced Premium Tax Credits

In addition to ending the government shutdown, one of the other topics Congress will soon need to address is the impending expiration of the enhanced premium tax credits (EPTCs) at the end of the year – especially with open enrollment beginning on November 1st.

As you know, the EPTCs originated in the American Rescue Plan Act in 2021 and were extended through the end of the 2025 in the Inflation Reduction Act. They have allowed people at 100-150% of the federal poverty level (FPL) to access plans with $0 premiums and low deductibles and other cost sharing. They have also allowed those with incomes above 400% of the FPL to access subsidies, capping their premiums at 8.5% of their income. According to the Kaiser Family Foundation, a 60-year-old couple in Wisconsin that makes $82,000 annually would see their premiums go up anywhere from $16,000 to nearly $23,000 (depending on where they reside in Wisconsin) for a benchmark silver plan if these EPTCs expire.

Wisconsin has seen an increase of nearly 120,000 people gaining insurance through a qualified ACA plan since these enhanced subsidies took effect in 2021. While it's impossible to attribute the entire gain to the enhanced

subsidies, they have undoubtedly played a role, and their expiration will likely lead to noticeable reductions in coverage which will in turn lead to more uncompensated care for hospitals.

In closing, this shutdown illustrates the need for more permanent authorization of these health care programs. Having only temporary authorizations creates significant uncertainty over whether appointments should be scheduled and whether various services will be paid. In addition to acting to end this shutdown, lawmakers should work to provide more permanency for these programs going forward.

Sincerely,

Kyle O'Brien
President & CEO