



The Hospital + Healthsystem
Association of Pennsylvania

April 16, 2026

The Honorable Dr. Debra Bogen
Secretary of Health
Pennsylvania Department of Health
Health and Welfare Building
625 Forster Street, 8th Floor West
Harrisburg, PA 17120

Dear Secretary Bogen:

Over the last three years, The Hospital and Health System Association of Pennsylvania (HAP) has appreciated the opportunities presented by the Department of Health to collaborate on a variety of initiatives aimed at improving patient care across the commonwealth, including opportunities to improve the regulatory environment for the 235 hospitals in our membership. The repeal of the department's notification requirements for new or updated pieces of equipment and the flexibility provided in the physician coverage guidance have dramatically reduced time spent on administrative tasks and have allowed hospitals to redirect financial resources where they are needed most.

During budget hearings, you noted that a regulatory package providing meaningful updates to the state's hospital licensure regulations would hopefully move to the proposed phase of the regulatory promulgation process next year. We know this process is extensive and commend the work of your team; however, the timeline has been significantly pushed back over the past 18 months. While we look forward to reviewing the department's proposals in their entirety, the new timeline means that hospitals will not see regulatory relief until 2029 at the earliest. The financial and administrative burden of the outdated hospital licensure regulations continues to impede the ability of hospitals to efficiently deliver care.

Given the implications of this timeline, we are requesting consideration of immediate opportunities to remove regulatory burdens that stand in the way of quality care. HAP and the hospital community have identified three priorities for relief, (attached) where administrative requirements increase costs while yielding little to no impact on patient safety. We believe these three issues can be resolved this year.

Pennsylvania is home to some of the nation's leaders in health care innovation. Improvements to the regulatory landscape would enable hospitals to reallocate resources currently tied to managing outdated systems to efforts aimed at leveraging cutting edge technologies, improving patient care, and better utilizing our health care workforce. Addressing the challenges listed below will make a meaningful difference for our hospital community at a critical time.



Secretary Bogen
April 16, 2026
Page 2

Thank you for your consideration. We look forward to working through hospitals' regulatory challenges and identifying additional opportunities for partnership to improve the health and health care of all Pennsylvanians.

Sincerely,

Nicole Stallings
President & Chief Executive Officer

Attachment: HAP Priority Recommendations for Regulatory Relief



The Hospital + Healthsystem
Association of Pennsylvania

Recommendations

1. Processes for Approving Construction Projects

Pennsylvania hospitals are investing in new capital improvements and construction projects that bring the latest technology and equipment to our communities and modernize outdated facilities. However, the current processes for reviewing and approving projects and assessing facilities for compliance with federal certification and state building and operational requirements have become cumbersome, often unnecessarily extending the timeline and adding costs to projects.

Our member hospitals recognize the need for oversight from the Division of Safety Inspection (DSI) on facility design and the Division of Acute and Ambulatory Care (DAAC) over clinical operations and appreciate the diversity in expertise offered by each. However, additional clarity is needed regarding the roles of each division and available pathways for communication.

The Department of Health (DOH) website indicates that plans and narratives must be submitted to DSI for all types of construction (new, alterations, and/or renovations) but does not define each. It is unclear if plan submission and review is needed when hospitals perform routine maintenance or repairs, and the interpretation of when this requirement applies varies by field office. Examples of repairs that we feel should not warrant a plan review include: installing new flooring that is the same or similar to the previous flooring, repairing a leak in a roof or replacing cabinets in exam rooms, particularly given the resource restraints that both DOH and community hospitals continue to work within.

For extensive renovations or new construction, architectural plans and drawings are typically required so that DSI can ensure the proposed projects meet the Guidelines for Design and Construction for Hospitals and other life safety and National Fire Protection Association codes. However, the regulated community needs a better-defined threshold for when an architectural plan will be required by the department. For example, if a hospital is replacing a roof but making no significant changes to the materials used or the shape or design of the roof, would an architectural plan be required?

Similarly, if issues with a project or an architectural plan are identified by the department (particularly in the later stages of a construction project), at what point will the department need a new or revised plan from an architect? For example, if after construction has taken place the DOH determines that an additional electrical outlet is needed, will the hospital be required to get a new architectural plan? Each time a hospital engages with an architectural firm, it comes at a significant cost (tens of thousands of dollars for even the most minor requests for updates) and, in many cases, the cost of additional plans does not seem warranted, particularly if the department would consider approving an exception request for the given scenario.

Recommendation: Issue guidance that provides hospitals with a framework or rubric to identify when a plan review by DSI would be required. The guidance should clearly identify when involvement from a third party, including an architectural firm, would be required and to



what extent. We strongly encourage the department to consider in its guidance the additional costs incurred each time a hospital is required to procure a new architectural plan.

Hospitals report a lack of clarity regarding which division has oversight of different sets of requirements. For example, hospital licensure regulations include a chapter for Fire, Safety, and Disaster Services (chapter 151) and Initial Construction and Continuing Operating Standards (chapter 153) that are also both seemingly under the purview of DSI. Similarly, both divisions are surveying spaces for compliance with Facility Guidelines Institute guidelines (room sizes and locations, etc.). Hospitals frequently report a lack of clarity on who the “authority” is on a given set of standards and report that they are often redirected from one division to another to decide whether they are compliant with a given regulation. They also report varying interpretations of guidelines for which both divisions have purview.

The lack of clarity is further compounded by inefficient communication pathways between DSI and DAAC. Hospitals often find themselves the intermediary between the two divisions when communications could be more centralized.

The regulated community needs efficient and expedient options for communicating between divisions if an issue is identified by a surveyor from one that requires input from the other division and/or one of its surveyors. For example, when new construction is completed, a DAAC occupancy survey cannot be scheduled until a DSI occupancy survey has been completed and proof of compliance issued to the hospital. Significant delays can occur in transferring the required approvals between divisions that further delay the timeline for an occupancy survey. Similarly, additional and unnecessary delays occur when DAAC surveyors come in for an occupancy survey and have questions for DSI surveyors but lack the appropriate platform to aid in direct interagency communications in real time.

The organizations embarking on these new construction projects are floating the costs of building, operating, and sometimes staffing while the divisions determine whether the applicable requirements have been met. HAP appreciates efforts from the Deputy Secretary to prioritize new construction projects but encourages the department to consider more formal remedies.

Recommendation: Issue written guidance that provides a clear delineation of which division will assess for compliance for each set of relevant requirements. For regulations or requirements that will be subject to review by both DSI and DAAC, identify formal pathways for facilitating interagency communication, ideally via a shared communication platform, but at a minimum, an agency policy or best practice that includes a team meeting with representation from the hospital and both divisions.

2. Hospital Membership within a System

Current regulations in Pennsylvania do not reflect a health system or multi-hospital model. They require health systems to create, maintain, and assure compliance of separate governing documents and bylaws for each individual hospital. Likewise, health systems must appoint medical staff, seek credentials, and grant privileges on a facility-by-facility basis. In some cases,



each provider must complete the entire onboarding process—two written references, verification of orientation and competencies, etc.—for each facility in which they may eventually practice. This makes it difficult, for example, to allow physicians and nurses to move easily between facilities and affects some specific clinical areas more than others, i.e., imaging, radiology, cardiology, sleep labs, etc. Compliance with these requirements adds a significant number of administrative tasks that ultimately do not change the quality of care or patient safety for patients.

At the federal level, regulations have been updated to allow health systems to manage staffing, human resources functions, governing body functions, compliance and quality reporting at a system level. For example, federal requirements permit a unified and integrated approach to medical staff credentialing and privileging across all facilities in a health system, which cuts red tape to allow well-qualified practitioners to treat patients when and where they are needed most. This flexibility is critical at a time when the health care workforce is so strained.

This issue is further complicated by the fact that CMS and The Joint Commission allow credentialing and privilege of providers for up to three years unless a shorter timeframe is required by state law. The commonwealth requires a two-year timeframe requiring these processes to be completed more frequently and creating misalignment with federal standards.

Recommendation: Create efficiencies for systems outside of the regulatory modernization package. Issue a statement of policy or interpretive guidance that would allow hospitals that are members of health systems to assign privileges at all hospitals within their system using one centralized process and extend the timeline for medical staff reappointment to three years. Alternatively, create a structured exception request that would allow hospitals to submit one request to put a centralized system in place.

3. Deemed Status for Ambulatory Surgical Facilities

During 2013, the Pennsylvania General Assembly passed Act 60 which allows accrediting organizations to provide accreditation and Medicare certification simultaneously. Under this arrangement, accrediting organizations can deem hospitals “in compliance” with federal and state licensure requirements during an accreditation survey in lieu of the DOH conducting an additional licensure renewal survey. This arrangement reduces regulatory burdens on both the hospital and state survey teams.

In Pennsylvania, Ambulatory Surgical Facilities (ASF) cannot use the “deemed status” process described above and must undergo two separate inspections—one by the accrediting organization and one by DOH for licensure. In instances when the ASF is licensed as a provider-based department or an outpatient department of the hospital, accrediting organizations will assess them for compliance as part of the hospital’s accreditation survey. For freestanding ASFs, accrediting organizations will assess them for compliance as part of a separate Ambulatory Health Care Accreditation process. In both cases, the surveys conducted by the accrediting organization could be used in lieu of an additional licensure renewal survey conducted by DOH.



The state's requirements for licensure renewal also exceed the federal requirements requiring that these surveys be conducted more frequently. (CMS only requires ASFs to be surveyed every three years, but DOH requires them to be surveyed every year.)

At least 21 states¹ recognize and rely on Joint Commission Ambulatory Health Care Accreditation (AHCA) in lieu of specific state licensure or certification requirements or surveys. These arrangements dramatically reduce the number of surveys required by DOH, reducing the strain on the agency's workforce and helping redirect resources towards projects for which a state-specific survey is needed.

Recommendation: Issue a statement of policy that extends deemed status (either through freestanding AHCA accreditations or hospital accreditations) to ASFs. Alternatively, support a legislative pathway that would achieve the same goal.

¹ [State Recognitions | Joint Commission](#)