The Hospital + Healthsystem Association of Pennsylvania

June 10, 2025

Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Unleashing Prosperity Through Deregulation of the Medicare Program Request for Information

Dear Administrator Oz:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), which represents 235 institutions across the commonwealth, thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) request for information (RFI) on deregulation of the Medicare program.

Health care is one of the most heavily regulated parts of the U.S. economy. While government oversight is appropriate to ensure that patients receive safe, high-quality care, the reality is that layers of regulatory requirements and processes too often stifle innovation, add unnecessary administrative burdens, strain facilities' finances, and take providers away from the bedside. Recent studies have found that providers spend an increasing amount of time on paperwork, not patients.[1] The growing number of regulations also increases costs, driving up the price of health care for everyone.[2] **Therefore, we strongly support your focus on deregulation.**

Hospitals in Pennsylvania struggle to keep pace with the changes in federal regulations as the state regulatory infrastructure becomes more outdated and compliance with both becomes more complex. Data suggests that an average-size hospital dedicates 59 employees to regulatory compliance and that more than a quarter of these are doctors and nurses. It is worth noting that this estimate reflects only time spent on compliance-

[1] John Noseworthy, *The Future of Care—Preserving the Patient-Physician Relationship*, NEW ENGL. J. MED. (Dec. 4, 2019), https://www.nejm.org/doi/full/10.1056/NEJMsr1912662; THE PHYSICIANS FOUND., *Viewpoints: Regulatory Burdens* (Jan. 2020), http://physiciansfoundation.org/wp-content/uploads/2020/01/PF-Issue-Brief-Regulatory-Burdens-final.pdf; LaPointe, Jacqueline, *Regulatory Burdens in Healthcare Take Away from Patient Care* (Nov. 15, 2023), https://www.techtarget.com/revcyclemanagement/news/366600273 /Regulatory-Burdens-in-Healthcare-Take-Away-from-Patient-Care.

[2] American Hospital Association, *Regulatory Overload Report: Assessing the Regulatory Burden on Health Systems, Hospitals, and Post-Acute Care Providers* (Oct. 2017), https://www.aha.org/sites/default/files/regulatory-overload-report.pdf; Nicol Turner Lee, et al., *Removing Regulatory Barriers to Telehealth Before and After COVID-19* (May 2020), Brookings Inst., https://www.brookings.edu/articles/removing-regulatory-barriers-to-telehealth-before-and-after-covid-19/.

related administrative activities and does not include clinical components of regulations or accreditation requirements. It is unacceptable that administrative activities to support compliance pull providers away from the bedside at a time when health care workforce shortages are at critical levels.

The cost of administrative activities related to regulatory compliance for health systems is exorbitant. An American Hospital Association (AHA) report (American Hospital Association, 2017) estimates that hospitals and post-acute providers collectively spend nearly $39 billion a year on the administrative activities related to regulatory compliance, which translates to $7.6 million annually for average-sized community hospitals (roughly 150 beds); $9 million for average-sized hospitals with post-acute care beds; and almost $19 million for hospitals with more than 400 beds. Based on these estimates, the federal regulatory burden equates to an average cost of $1,200 per patient admitted, or $47,000 per hospital bed, per year.

As you consider ways to mitigate regulatory and administrative challenges in the health care system, we encourage you to refer to the comments submitted by the AHA and its list of 100 Ways to Free Hospitals from Wasteful and Burdensome Administrative Requirements to Provide the Highest Quality, Most Efficient Care to Patients.

HAP emphasizes the need for regulatory reform in the following priority areas organized according to the framework provided in the RFI.

Opportunities to Reduce Administrative Burden of Reporting and Documentation

Research estimates that between 25–30 percent of all health care spending goes toward administrative tasks, not patient care.[3] These tasks include verifying patients' insurance and coverage status, conducting prior authorizations, and acquiring and managing the personnel and technology to comply with different payment models and payor requirements. To reduce billing and payment-related burden, we recommend the following:

Standardize more insurance-related administrative transactions. In Pennsylvania, 54 percent of Medicare beneficiaries (or 1.6 million individuals) are enrolled in a Medicare Advantage plan. There has been a 60 percent increase in the number of Pennsylvanians enrolled in Medicare Advantage plans over the last ten years.

[3] https://www.healthaffairs.org/content/forefront/administrative-spending-contributes-excess-us-health-spending

HAP members frequently encounter challenges in working with Medicare Advantage organizations (MAO) and securing timely authorization and payment for patient care, which can result in unnecessary delays and increased administrative burdens. These challenges often include misuse of utilization management programs, inappropriate denial of medically necessary services that would be covered by Traditional Medicare, requirements for unreasonable levels of documentation to demonstrate clinical appropriateness, and inadequate provider networks to ensure patient access.

HAP joins the AHA in advocating that CMS enforce the Interoperability and Prior Authorization Final Rule (CMS-0057-F) which will streamline electronic prior authorization processes across payors. Additional actions CMS could consider to further standardize and improve administrative transactions include:

- Eliminating billions of dollars in excess health care system costs by establishing prompt pay requirements in all forms of health care coverage, including Medicare Advantage.
- Eliminating duplicative and costly billing infrastructures within hospitals, health systems, and other providers by shifting cost-sharing collection responsibilities to insurers—the entities that set co-pay, deductible, and co-insurance amounts.

Make all Center for Medicare and Medicaid Innovation (CMMI) models voluntary and eliminate the Transforming Episode Accountability Model (TEAM) (42 CFR 512.5) and repeal the Inpatient Rehabilitation Facility (IRF) Review Choice Demonstration. While we strongly support innovation to improve the quality and accessibility of health care at lower costs, some of the CMMI models as designed could have an immediate detrimental impact on the quality of care or on patients' access to care by overburdening their providers.

The TEAM would mandate that over 740 acute care hospitals receive bundled payments for five types of surgical episodes, irrespective of whether the hospitals are able to implement the bundles and whether they will improve patient care. In Pennsylvania, these requirements would apply to 26 hospitals (more than ten percent of hospitals statewide). The model particularly targets hospitals with low levels of existing experience with alternative payment models, increasing the risk that participating in such a model could financially destabilize them, threatening access to care for everyone in the community.

Similarly, under the IRF Review Choice Demonstration, IRFs have 100 percent of their Traditional Medicare claims subject to unnecessary and onerous pre- or post-claim review for at least six months. Pennsylvania was the second state selected to rollout this program and began implementation in June of last year. Billing under the program adds

considerable staffing costs to providers who are already struggling under rising input costs and unstable revenue. Pre-claim reviews under the program to date have found hospital practices to be overwhelmingly compliant.

Repeal the excessive, confusing, and imbalanced provider disincentives included in the June 2024 final rule "21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking" (RIN 0955-AA05). Under the final rule, hospitals and providers found to engage in information blocking may face reductions in Medicare payment updates, adjustments to reimbursement rates, lower performance scores, and potential ineligibility for certain incentive programs. We believe in the importance of making critical health information available to patients, the clinicians treating those patients, and those with appropriate reasons for having access, among which are payment, care oversight, and research staff. However, the disincentive structure in this rule is excessive, so much so that it may threaten the financial viability of economically fragile hospitals, including many small and rural hospitals.

Opportunities to Streamline Regulatory Requirements

High-quality, safe care is the core of hospitals' missions. While many regulations originated out of an interest to improve care quality or patient safety, those same regulations, over time, have often become obsolete or redundant. Hospitals and health systems spend billions of dollars annually just on collecting and submitting quality measures, with one survey estimating annual per hospital costs of $3.5 to $12 million.[4,5]

Repeal outdated COVID-19 reporting mandates. As noted above, data reporting is an incredibly time intensive activity that pulls clinicians away from patients and costs a considerable amount in both staff time and technology to complete. While we are deeply committed to ensuring the highest quality care, it is imperative that we direct our limited resources to the highest impact areas. Unfortunately, hospitals are subject to significantly outdated reporting requirements, in particular with respect to the COVID-19 public health emergency (including 86 FR 42489, 86 FR 45446, 86 FR 42396, 88 FR 51009, 88 FR 53233, 88 FR 59250, 88 FR 77767 (for post-acute care patients/residents and staff), 86 FR 45382 (for hospital staff), and 42 CFR 482.42(e), 42 CFR 483.90(g), 42 CFR 485.426(e), and 42 CFR 485.640(d)). Eliminating this unnecessary reporting

[4] "The volume and cost of quality metric reporting," Sarawasthula A et al. Journal of the American Medical Association. Volume 329, Number 21. June 6, 2023. 1840-1847.
[5] "Observations from the field: Reporting Quality Metrics in Health Care." Dunlap NE et al. National Academies Press; 2016. https://nam.edu/wp-content/uploads/2016/07/Observations-from-the-Field-Reporting-Quality-Metrics-in-Health-Care.pdf

would reduce costs in the health care system and enable providers to spend more time with their patients.

Replace the sepsis bundle measure, as required at 79 FR 50241 and 88 FR 59801, with a measure of sepsis outcomes. Hospitals have spent considerable effort—and achieved significant results—in mitigating the incidence and severity of sepsis, saving lives in the process. Unfortunately, research has demonstrated that the sepsis bundle measure has not led to better outcomes yet entails enormous administrative burden. We encourage the administration to work with hospitals on a measure that will help them further advance the fight against sepsis, while reducing unnecessary burdens in the system.

Resume conducting low-risk complaint surveys virtually. During the COVID-19 pandemic, CMS adopted a policy in which accrediting organizations (AO) and state survey agencies could conduct complaint surveys of low-risk quality issues virtually. Since then, CMS has instructed AOs to conduct most complaint surveys in person, regardless of severity, and hospitals incur the costs for each AO visit. Virtual surveys for low-risk complaints would enable more efficient use of survey resources and reduce administrative costs. Similarly, HAP would request that CMS allow hospitals time to ensure adequate staffing and resources during surveys without compromising the integrity of those surveys by eliminating the prohibition on accrediting organizations providing same-day notification of a survey.

As technology and consumer preferences have evolved, more care can safely be delivered via telehealth. However, numerous regulations restrict the use of virtual care, impeding innovation and our ability to deliver care more efficiently. While there are numerous ways to expand access to care using telehealth, we recommend starting with the following:

- *Remove telehealth originating site restrictions within the Medicare program at Sec. 1834(m)(4)(C)(ii)(X) of the Social Security Act (42 U.S.C. 1395m) and 42 CFR 410.78(b)(3) to enable patients to receive telehealth in their homes.* Under current rules, patients must be in a clinical site of care, which completely undermines the value of telehealth for patients, limits its adoption, and adds costs for providers.
- *Remove telehealth geographic site restrictions within the Medicare program at Sec. 1834(m)(4)(C)(i) of the Social Security Act (42 U.S.C. 1395m) and 42 CFR 410.78(b)(4) to enable beneficiaries in non-rural areas to have the same access to virtual care as those in rural areas.*
- *Remove the in-person visit requirements for behavioral health telehealth at Sec. 1834(m)(7) of the Social Security Act (42 U.S.C. 1395m) and 42 CFR*

410.78(b)(3)(xiv), which are unnecessary, add a barrier to access, and create a disparity between physical and mental health services.

Streamline care plan documentation requirements at 42 CFR 483.23(b)(4). To provide higher quality, more holistic care, patients are increasingly cared for by interdisciplinary teams. These teams may include a range of clinical professionals, such as nurses, therapists and social workers. When used, these teams develop what is known as an interdisciplinary care plan. Yet, outdated regulations require nursing-specific care plans. Hence, as more care moves to interdisciplinary teams, clinicians must create duplicate paperwork to document the care plan.

The changes above would go a long way to ease the administrative burden on hospitals in Pennsylvania, enhancing our ability to provide the highest quality care in the most efficient manner. We appreciate your consideration of these comments.

Sincerely,

Kate McCale

Kate McCale, MPH
Vice President, Compliance and Regulatory Affairs