Illinois Health and Hospital Association

June 5, 2025

Honorable Robert F. Kennedy Jr.
Director U.S. Department of Health and Human Services
200 Independence Ave SW Washington, DC 2001

Honorable Mehmet Oz, M.D.
Administrator Centers for Medicare & Medicaid Services
7500 Security Boulevard Baltimore, MD 21244-1850

RE: Fiscal Year 2026 Inpatient Prospective Payment System Request for Information: Deregulation (CMS-1833-P)

Dear Secretary Kennedy and Administrator Oz:

On behalf of the Illinois Health and Hospital Association's more than 200 hospitals and nearly 40 health systems, we thank you for the opportunity to provide feedback on burdensome administrative requirements that impede access to healthcare for Illinoisans, preventing them from living their healthiest lives. We agree with the administration's stance that the health status of too many Americans does not reflect the greatness of our nation nor the expertise, innovation, and capability of our healthcare system. Excessive regulatory and administrative burdens are a key contributor to this reality, as they add unnecessary cost to the healthcare system, reduce patient access to care and stifle innovation.

Below we outline opportunities for the administration to reduce administrative and regulatory burden on hospitals and health systems. We thank you for considering these issues and look forward to working with the administration to Make American Health Again.

Please contact Cassie Yarbrough, Assistant Vice President, Health Policy and Finance, with any questions at cyarbrough@team-iha.org or 630-276-5516.

Sincerely,

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Addressing Wasteful and Burdensome Administrative and Regulatory Requirements for Healthcare to Provide the Highest Quality, Most Efficient Care to Patients

Health Plans

- Reduce variation in prior authorization processes by enforcing the interoperability and prior authorization final rule which streamlines electronic prior authorization processes across multiple payers.
- Establish a single clinical standard for both traditional Medicare and Medicare Advantage to use to adjudicate claims.
- Reduce the time patients spend waiting for post-acute care placements by disallowing plans from implementing prior authorization requirements for these services.
- Eliminate duplication and data collection burdens on providers by establishing a single national provider directory and requiring plans to exclusively use the national database rather than create their own.
- Adopt a standard Medicare Advantage plan appeals process for providers.
- Minimize the burden of managing pharmaceutical supplies while improving patient safety by prohibiting insurers from unilaterally adopting policies that force providers to use pharmaceuticals provided by the insurer's affiliated pharmacy benefit manager rather than using their own supply (also known as "white bagging").

Information Technology and Coding

- Repeal the June 2024 final rule "21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking" (RIN 0955-AA05). The "information blocking" rule is confusing for patients and imposes unjustified penalties on providers.
- Modify the Health Insurance Portability and Accountability Act of 1996 (HIPAA) cybersecurity rule of December 2024 to make the requirements voluntary.
- Modify the HIPAA Breach Notification Rule to remove the requirement to report breaches affecting fewer than 500 individuals.
- Facilitate whole-person care by eliminating 42 CFR Part 2 requirements that hinder care team access to important health information and protect patient privacy under HIPAA. The regulations in Part 2 are outdated, fail to protect patient privacy and erect

sometimes insurmountable barriers to providing coordinated, whole-person care to people with a history of substance use disorder (SUD).
- Streamline the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) code sets to standardize reporting across all payors.

Administrative and Regulatory Barriers to Care
- Repeal the Institutions for Mental Disease exclusion within the Medicaid program so that hospitals and other providers can ensure Medicaid patients who need inpatient behavioral healthcare can efficiently get the most effective care.
- Repeal the 180-day lifetime limit on inpatient psychiatric facility services under Medicare.
- Eliminate the two-midnight inpatient rule that establishes an arbitrary guideline for inpatient care that is not based on clinical criteria.
- Modernize the Stark Law and Anti-kickback Statute regulations to better protect arrangements that promote value-based care.
- Expand hospitals' ability to utilize swing beds.
- Improve the timeliness and efficiency of 340B child site registration by re-adopting the prior policy of allowing hospitals to register child sites under the 340B program even if they are not included on their most recently filed cost report.

Medicare Payment and Processes
- Enforce timeliness requirements on Medicare Administrative Contractors (MACs) to settle Medicare cost reports within one year. This timeline is important for hospitals so they can properly state amounts due to/from Medicare and address any issues identified in the cost report settlement process before another cost reporting period lapses.
- Repeal the IRF Review Choice Demonstration under which IRFs will have 100% of their traditional Medicare claims subject to either pre- or post-claim review for at least six months.
- Repeal the Center for Medicare and Medicaid Innovation's (CMMI) Increasing Organ Transplant Access mandatory kidney transplant model that purports to better align payment with quality but over-focuses on quantity over quality.
- Make voluntary all CMMI models with particular focus on the recently announced Transforming Episode Accountability Model, which will mandate that some of the most vulnerable hospitals transition to bundled payments for five types of surgical episodes.
- Eliminate the skilled nursing facility three-day length of stay requirement that often delays patients from transitioning to the most appropriate site of care.

- Eliminate the CAH 96-hour rule as a condition of participation (CoP) which requires an annual average length of stay of 96 hours or less and eliminate the 96-hour condition of payment rule that requires physicians in CAHs to certify upon admission that an inpatient can be reasonably expected to be discharged or transferred to another hospital within 96-hours.
- Eliminate the "must-bill" policy for dual eligible beneficiaries, which requires providers to bill both Medicare and Medicaid even though no Medicaid payment may be expected.
- Allow for exceptions to the requirement that Medicare overpayments are returned in 180 days, given that providers may need additional time to complete investigations.
- Allow Medicare bad debts to be written off as contractual allowances, which is consistent with standard accounting practices and was permitted under prior policies.
- Eliminate the policy that to receive Medicare bad debt reimbursement for dual eligible beneficiaries, providers must bill the state Medicaid program and receive/submit the remittance advice listing any Medicaid payment, which is burdensome and not always possible.
- Standardize coverage, coding and billing criteria among MACs.
- Remove the restriction that disallows hospitals from choosing a different MAC.
- Streamline Medicare mandatory notices to patients, including eliminating where applicable rules require providers to give notice both in-person and via paper notices. Examples of such notices include the Important Message from Medicare, Advance Beneficiary Notice of Non-coverage, and Medicare Outpatient Observation Notice, the Notice of Medicare Non-Coverage and Medicare Change of Status Notice.
- Rescind Centers for Medicare & Medicaid Services (CMS) regulations requiring hospitals to report detailed information about drug invoices on their cost reports beginning in 2026. Manufacturers should be required to report the additional pricing information necessary for CMS to create average sales prices
- Revise Medicare drug price negotiation guidance to prohibit drug manufacturers from implementing retrospective rebate models in the 340B Drug Pricing Program, which would add considerable administrative costs to hospitals serving the most vulnerable communities.
- Strengthen Medicare-dependent and Sole Community Hospitals by allowing participating hospitals to choose from an additional base year when calculating payments.

Price Transparency

- Eliminate the convening provider requirement as part of good faith price estimates given to patients, because there is no technical solution to operationalize it.
- Revise hospital price transparency requirements that replicate health plan transparency in coverage. Health plans are the best source of information on out-of-pocket costs for insured patients.

Quality Reporting

- Repeal the CoP that requires hospitals to report data on acute respiratory illnesses, including influenza, COVID-19 and RSV, once per week, with more frequent and extensive data reporting required during a public health emergency.
- Reduce administrative burden by eliminating the outdated requirement for post-acute care providers to report COVID-19 and influenza vaccine rates for patients/residents and staff.
- Remove the sepsis bundle measure, which evidence shows has not led to better outcomes but entails an enormous administrative burden, from all hospital quality reporting and value programs, replacing it with a measure of sepsis outcomes.
- Eliminate or at minimum streamline the Meaningful Use program that is no longer relevant.
- Eliminate or, at a minimum, significantly streamline the onerous Hospital Consumer Assessment of Healthcare Providers and Systems (patient satisfaction) survey of hospitals, as the instrument is largely unusable and unreliable due to low response rates.
- Support quality and patient safety while reducing burdens by reducing the required reporting of electronic clinical quality measures to a more targeted set of core measures.
- Suspend the Medicare hospital star ratings program as the methodology is inadequate, including distorted comparisons of hospital performance and a significant time lag.
- Remove quality measures from the inpatient psychiatric quality reporting program that are not directly relevant to inpatient psychiatric care, such as whether the facility offers smoking cessation services.
- Remove all structural measures from hospital quality reporting programs that have little evidence tying their use to better care or outcomes, including the Patient Safety Structural Measure and Age-Friendly Hospital measure.
- Remove or, at a minimum, make voluntary the reporting of hybrid hospital readmissions/mortality measures and hip/knee arthroplasty patient-reported outcome measures due to significant feasibility issues.

Surveys and Accreditation

- Minimize in-person hospital surveys for low-risk complaints and resume them virtually.
- Permanently adopt concurrent validation surveys for CMS accrediting organizations, eliminating duplicative "lookback" surveys that require a full resurvey of hospital compliance with CoPs.
- 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.
- Eliminate punitive removals of "deemed status" when a hospital has one or more condition-level citations on a validation survey, which is unnecessary for adequate oversight.

Other

- Revise the obstetrical care CoP by removing requirements that are not directly relevant to improving obstetrical care and redundant with existing requirements, such as requirements focused on non-obstetrical emergencies, supplies and training.
- Remove the requirement that hospitals provide translation services for patients in 15 different languages and instead allow hospitals to ensure adequate translation for the populations they serve.
- Enable inpatient psychiatric facilities (IPFs) to provide appropriate monitoring of patients at risk of suicide without overburdening the workforce or adding unnecessary costs by eliminating the requirement that IPFs have one-to-one monitoring of patients at risk of suicide.
- Enable hospitals to reduce costs by limiting the requirement to purchase supplies through CMS-approved vendors to only medical devices and other aspects of direct patient care and exempting non-clinical items such as office furniture and supplies.
- Support providers' access to cheaper drugs by enforcing rules to prevent gaming of patents and other policies that stifle pharmaceutical competition.
- Revise direct supervision requirements to allow clinicians to practice at the top of their license and better allow flexibility to reflect modern care delivery models.
- In the 2024 Medicare outpatient prospective payment system (OPPS) final rule, CMS finalized a change to the definition of Opioid Treatment Program Intensive Outpatient Program services to allow the required certifications to be performed by non-physician practitioners. We recommend amending 42 CFR § 410.44(a)(3) and 42 CFR § 424.24(d) to consistently apply this permission across all Intensive Outpatient Programs, allowing advance practice providers like Advanced Practice Nurses and Physician Assistants to utilize their full scope of practice and work to the top of their license.

- Reform nursing and allied health education payments to relax the CMS interpretation of "director control." Additionally, reevaluate payment for allied health training. Historically, Medicare has allowed reasonable cost reimbursement for costs incurred by hospitals to train allied health professionals. In recent years, MACs are routinely disallowing the passthrough treatment of these costs, forcing hospitals to absorb these costs without any recognition of the costs in the various prospective payment rate setting processes. Due to lack of cost report settlement timeliness, several years may lapse between when the hospital incurs the cost and the reimbursement determination is made, meaning that if the cost is disallowed, there will likely be several more years at risk.
- Revise the current audit process for Interns and Residents. CMS currently reviews several cost reporting years for academic medical centers and other hospitals where residents may be assigned. The purpose of these audits is to eliminate any duplication of residents being counted by multiple institutions for the same period of time. Overlaps, however, arise due to the way different hospitals track assignments. The retroactive nature of these audits can result in lost reimbursement and require significant resources to resolve or concede the overlaps. This issue would also be helped by the cost report timeliness issue detailed above.

Telehealth

- Remove telehealth originating site restrictions to enable patients to receive telehealth in their homes.
- Remove telehealth geographic site restrictions to enable beneficiaries in non-rural areas to have the same access to virtual care as those in rural areas.
- Remove restrictions on telehealth modalities to enable a wider range of services (e.g., audio only) to be safely delivered via telehealth.
- Remove restrictions on the provider types eligible to perform telehealth.
- Remove restrictions on the types of distant sites eligible to perform telehealth services.
- Allow hospital outpatient departments to bill for telehealth services when patients are in their homes (assuming statutes are updated to allow for telehealth to patients' homes permanently).
- Remove the in-person visit requirements for behavioral health telehealth.
- Remove restrictions to allow new patients to receive remote physiologic monitoring.
- Remove case-by-case approval of new telehealth services; instead, include all Medicare-covered services as eligible telehealth services and remove them on a case-by-case basis.

- Remove in-person visit requirements prior to prescribing controlled substances by establishing a special registration process for virtual prescribers.
- Remove requirements for hospice recertification to be completed in person to allow for telehealth-based recertification.

Workforce

- Eliminate the telehealth physician home address reporting requirement, which compromises workforce safety.
- Remove requirements for outpatient physical therapy plans of care to be signed off by a physician or nurse practitioner every 90 days.
- Repeal the Federal Trade Commission's Non-Compete Clause Rule.
- Reform rules related to “fair market value” to ensure that hospitals can obtain access to necessary specialist services.
- Eliminate nurse practitioner practice limitations that are more restrictive under CMS rules than under state licensure.
- Promote medical licensure reciprocity to allow practitioners to work across state lines.
- Do not promulgate Occupational Safety and Health Administration federal workplace violence regulations that would be duplicative of the rigorous accreditation requirements hospitals already face and add an administrative burden.
- Reduce unnecessary costs in the system by pursuing medical liability reform by eliminating joint and several liability.
- Cap non-economic and punitive damages as part of medical liability.