THE REGULATORY BURDEN CRUSHING AMERICAN HOSPITALS

How Congress and the Administration can reduce waste, protect patient care, and save hospitals up to $166 billion over 10 years

$77B–$166B	$117B	$8B–$17B
Projected 10-year net hospital savings	**Central 10-year savings estimate**	**Recurring annual savings after implementation**

Hospitals are drowning in paperwork while payment cuts accelerate.

American hospitals are required to navigate overlapping federal and state rules, duplicate data submissions, manual chart abstraction, repeated attestations, fragmented audits, and increasingly complex billing and reporting systems. The result is a vast administrative apparatus that consumes scarce clinical and financial resources—often without improving safety, quality, transparency, or patient access.

This report identifies ten targeted federal reforms that could substantially reduce this burden while preserving the protections that matter most. The largest opportunities include consolidating quality reporting, automating "report once" data submission, reducing repetitive Conditions of Participation documentation, coordinating audits, simplifying provider enrollment, and eliminating low-value reporting that duplicates information already held by government.

THE COST OF INACTION

- Hospital reporting and compliance can consume tens of thousands of staff hours each year.
- Clinicians are pulled away from patient care to support documentation, validation, and audit work.
- New mandates are arriving as Medicare payment reductions threaten the resources needed to comply.

THE OPPORTUNITY

- $5–$13 billion in estimated net savings in Year 1.
- $8–$17 billion in recurring annual savings as reforms mature.
- More staff time for nursing, patient access, care coordination, cybersecurity, and clinical improvement.

THE POLICY CHOICE IS CLEAR

Congress and federal agencies can continue adding cost and complexity—or modernize hospital oversight so that accountability is preserved and resources return to patient care.

Prepared by Strategic Health Care

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The Growing Administrative, Regulatory Burden that Is Crushing American Hospitals

Overview and Opportunity

If the ten targeted federal regulatory reforms described in this summary were enacted and fully implemented, U.S. hospitals and health systems could realize an estimated $77 billion to $166 billion in net administrative savings over a 10-year federal budget window, with a central estimate of approximately $117 billion.

These savings would come from eliminating duplicative reporting, automating data submission, reducing repetitive documentation, coordinating audits, and simplifying other low-value compliance processes while preserving patient-safety, quality, privacy, emergency-preparedness, and program-integrity protections. The reforms could produce approximately $5 billion to $13 billion in net savings in Year 1, rising toward $8 billion to $17 billion annually by Years 2 and 3 as transition costs decline and automation matures.

Importantly, more costly regulations are coming from Congress and the Administration. Some of these are detailed in this report.

Executive Summary

Medicare and Medicaid participation requires hospitals to submit extensive financial, claims, quality, safety, pricing, enrollment, emergency preparedness, and compliance information. These federal requirements sit alongside state Medicaid rules, public health reporting, accreditation standards, workplace and environmental requirements, privacy and cybersecurity obligations, controlled-substance controls, and payer-specific administrative processes. Against this backdrop, the central fiscal opportunity is substantial: targeted simplification could generate approximately $77 billion to $166 billion in net hospital savings over 10 years, with a central estimate near $117 billion.

The burden is cumulative. Similar data may be requested by different agencies using different definitions, formats, portals, reporting periods, and audit standards. Each new mandate can require workflow redesign, contract and coding review, electronic health record or revenue-cycle modifications, data reconciliation, staff training, executive certification, and ongoing audit support.

The evidence confirms a large administrative footprint. A 2025 Health Affairs Scholar analysis of 5,639 hospitals found approximately $166.1 billion in reported administrative expenses out of $974.5 billion in total expenses, or about 17%. This is not a measure of regulation alone, but it demonstrates the scale of hospital administrative infrastructure. A separate study estimated that investigating and reporting a serious reportable event cost approximately $8,000 per event. A 2024 JAMA Internal Medicine study found that administrative requirements can reduce clinician efficiency, increase frustration and complexity, and diminish time available for patient care.

Ten regulatory modifications required to achieve the projected savings

1. **Consolidate duplicative hospital quality measures.** Create one core federal measure set across the Hospital Inpatient Quality Reporting (IQR) Program, Hospital Outpatient Quality Reporting (OQR) Program, Hospital Value-Based Purchasing (VBP) Program, Hospital Readmissions Reduction Program (HRRP), Hospital-Acquired Condition (HAC) Reduction Program, Promoting Interoperability Program, and Care Compare; retire topped-out, duplicative, and low-value measures.

2. **Replace manual clinical-data abstraction with automated "report once" submission.** Use standardized EHR, claims, registry, and federal-repository data so validated information is extracted once and reused across authorized programs.
3. **Eliminate or substantially narrow Medicare Advantage Worksheet S-12.** Obtain negotiated-payment information from Medicare Advantage organizations or use statistically valid sampling rather than universal hospital reporting.
4. **Consolidate federal hospital price-transparency reporting.** Use one national data specification and federal repository, eliminate duplicative hospital and insurer submissions, and retain consumer-facing out-of-pocket estimates.
5. **Create one federal infection and public-health reporting pathway.** Align CMS, CDC, National Healthcare Safety Network (NHSN), and federally supported state reporting so hospitals do not repeatedly submit the same surveillance data through different portals.
6. **Simplify Medicare and Medicaid provider enrollment and revalidation.** Prepopulate federal forms, require change-only updates, permit system-level submissions, and use a common ownership and enrollment database.
7. **Reduce repetitive Conditions of Participation documentation.** Preserve substantive patient-safety standards while eliminating repeated attestations, unchanged policy approvals, duplicative credentialing files, and process documentation unrelated to outcomes.
8. **Streamline emergency-preparedness documentation and exercises.** Allow actual emergencies, regional exercises, and system-wide exercises to satisfy overlapping requirements and permit change-only plan updates.
9. **Establish one coordinated federal audit and data-validation process.** Prevent duplicate reviews of the same claims and issues, coordinate contractor requests, standardize look-back periods, and permit one corrective-action plan.
10. **Modernize Stark Law and Anti-Kickback regulations for clinically integrated care.** Expand clear safe harbors for legitimate value-based, care-management, telehealth, cybersecurity, transportation, and clinical-integration arrangements while preserving enforcement against intentional abuse.

Why 2026-2027 is especially consequential

- CMS has proposed major FY 2027 outpatient payment changes, including a deep reduction in payment for separately payable 340B drugs and expansion of site-neutral payment to specified imaging services in grandfathered off-campus hospital departments.
- CMS is adding new Medicare Advantage payment reporting through Medicare Cost Report Worksheet S-12, requiring hospitals to assemble negotiated payment data across contracts and service lines.
- Expanded hospital price-transparency requirements and machine-readable file specifications continue to increase recurring data-governance, legal, contracting, and IT work.
- House Ways and Means Committee Republicans advanced legislation that would impose detailed new federal reporting requirements on tax-exempt hospitals, including community benefit, financial assistance, service-line, advertising, and 340B disclosures.

Bottom line: Hospitals are being asked to provide more data, meet more detailed standards, and absorb new implementation costs at the same time that proposed payment policies would reduce resources available to support care delivery and compliance.

1. Evidence of a Large and Growing Administrative Footprint

Medicare Cost Reports and hospital administrative expense

The 2025 Health Affairs Scholar study, "Availability of Consistent, Reliable, and Actionable Public Data on U.S. Hospital Administrative Expenses," analyzed Medicare Cost Report data from 5,639 hospitals. Medicare Cost Reports contain nearly 30 worksheets, extensive instructions, and detailed annual operational and financial submissions to CMS.

Measure	
Hospitals analyzed	5,639
Total reported expenses	Approximately $974.5 billion
Administrative expenses	Approximately $166.1 billion
Administrative share	Approximately 17% of total expenses

Interpretation. The 17% estimate includes broad administrative functions and should not be described as the cost of federal regulation. It does, however, show the magnitude of the personnel, accounting, data, management, and information-system infrastructure upon which reporting mandates depend.

Hidden cost of mandatory event reporting

The Joint Commission Journal on Quality and Patient Safety study, "The Hidden Cost of Regulation: The Administrative Cost of Reporting Serious Reportable Events," evaluated the cost of investigating and reporting events at an academic medical center. The estimated administrative cost was approximately $8,000 per reported event. The work included clinical review, root-cause analysis, documentation, leadership review, corrective-action development, and regulatory submission.

This illustrates why reporting costs are often underestimated. The final electronic submission may take only a fraction of the total time; most expense arises from multidisciplinary investigation, validation, meetings, legal and compliance review, and the opportunity cost of clinical and leadership participation.

Clinician and workforce consequences

The 2024 JAMA Internal Medicine study, "Identifying and Measuring Administrative Harms Experienced by Hospitalists and Administrative Leaders," identified regulatory requirements, documentation expectations, compliance activities, and internal administrative processes as common sources of harm. Reported effects included reduced clinician efficiency, workforce frustration, greater operational complexity, and less time for patient care.

What the available evidence does - and does not - establish

- There is no single CMS or Medicaid figure that captures total annual hospital reporting hours across all programs.
- Peer-reviewed studies establish that administrative expense and reporting labor are material, but they measure different portions of the burden.
- Operational estimates of hours, FTEs, and labor costs are useful for planning and advocacy, but should be labeled as illustrative rather than official federal estimates.
- Broader payer administration, including prior authorization, denials, appeals, and payer-specific billing rules, adds to the same workforce burden but is not identical to regulatory compliance.

2. Scope of Federal and State Hospital Reporting

A typical acute-care hospital reports through dozens of programs. The obligations span payment, quality, safety, transparency, public health, workforce, environmental protection, controlled substances, privacy, civil rights, cybersecurity, and program integrity.

Agency or program	Major hospital reporting and documentation responsibilities
CMS - Medicare	Cost Reports; claims; IQR and OQR; VBP; HRRP; HAC Reduction; Promoting Interoperability; Hospital Price Transparency; Worksheet S-12; Conditions of Participation; emergency preparedness; enrollment and

Agency or program	Major hospital reporting and documentation responsibilities
	revalidation.
Medicaid agencies and MCOs	Claims and encounters; DSH; cost reports; supplemental and state-directed payments; upper payment limit programs; provider taxes; quality reporting; enrollment; audits. Requirements vary substantially by state.
CDC and public health	NHSN infection surveillance; healthcare-associated infections; antimicrobial resistance; vaccination and respiratory disease reporting; emerging pathogen reporting.
HHS OCR	HIPAA privacy, security, breach reporting, risk analyses, civil-rights compliance, and language-access documentation; proposed Security Rule changes could expand cybersecurity documentation.
ASTP/ONC	Certified EHR compliance, information blocking, interoperability certification, and applicable TEFCA documentation.
OSHA	OSHA 300/300A/301; bloodborne pathogens; respiratory protection; hazard communication; PPE; exposure monitoring; medical surveillance; injury and workplace-violence documentation.
EPA	Hazardous and pharmaceutical waste; RCRA; EPCRA Tier II; TRI where applicable; refrigerants; emissions; wastewater; universal waste; spill-prevention plans.
DEA, FDA, OIG, DOJ, DHS/CISA	Controlled-substance inventories and loss reporting; device and biologic adverse events; compliance and self-disclosure; audit and investigation support; cybersecurity incident and risk documentation as implemented.

Cross-agency friction

- Definitions differ by agency and state.
- Reporting calendars and look-back periods are not aligned.
- Data formats and portals are not interoperable.
- Audit documentation and retention standards differ.
- The same underlying clinical or financial information may be extracted, reformatted, certified, and submitted multiple times.

Multi-state systems face disproportionate Medicaid burden because every state may use different cost-report formats, quality measures, encounter specifications, supplemental-payment methodologies, provider-assessment rules, DSH audit requirements, and reporting calendars.

3. Illustrative Annual Reporting Hours, Staffing, and Labor Cost

The following estimates are based on typical hospital regulatory staffing models, quality-reporting workloads, reimbursement operations, Medicare Cost Report requirements, Medicaid administrative complexity, and compliance functions. They are planning estimates, not official CMS measurements or nationally validated benchmarks.

Organization	Medicare hours	Medicaid hours	Total annual hours
Small hospital (100-250 beds)	15,000-25,000	8,000-20,000	23,000-45,000
Medium hospital (250-500 beds)	25,000-50,000	15,000-35,000	40,000-85,000
Small system (2-5 hospitals)	75,000-150,000	50,000-125,000	125,000-275,000
Large system (20-50+ hospitals)	500,000-1,000,000+	300,000-750,000+	800,000-1.75 million+

Illustrative labor cost at $100-$150 per fully loaded hour

Organization	Annual reporting hours	Estimated annual labor cost
Small hospital	23,000-45,000	$2.3M-$6.8M
Medium hospital	40,000-85,000	$4.0M-$12.8M
Small health system	125,000-275,000	$12.5M-$41M
Large health system	800,000-1.75M	$80M-$260M

Illustrative breakdown for a 300-bed hospital

Function	Annual hours
Medicare cost reporting and reimbursement	3,000-6,000
Medicare quality reporting: IQR/OQR/VBP/HAC/HRRP	8,000-15,000
Clinical data abstraction and validation	8,000-15,000
Infection reporting	3,000-6,000
Medicaid claims, DSH, managed care, and supplemental payments	8,000-15,000
Medicaid quality reporting	3,000-8,000
Data analytics and reporting infrastructure	5,000-10,000
Compliance review, audits, and documentation	3,000-7,000
Total	**40,000-85,000**

At 2,080 hours per full-time equivalent, 40,000-85,000 hours equals roughly 19-41 FTE-years. Actual staffing may be distributed among many more employees who devote only part of their time to reporting. Personnel commonly include quality staff, reimbursement specialists, analysts, HIM staff, compliance personnel, finance staff, IT and data support, clinicians, and managers.

4. New and Expanded Requirements: 2025-2027

Medicare Advantage Worksheet S-12

Beginning with applicable Medicare cost reporting periods ending on or after January 1, 2026, CMS requires affected IPPS hospitals to report median negotiated Medicare Advantage payment information by MS-DRG on

Worksheet S-12. Hospitals must collect, map, reconcile, validate, and document negotiated payment data across contracts, often involving finance, managed care contracting, reimbursement, revenue cycle, analytics, and IT.

- Illustrative initial implementation: 500-2,000 hours per hospital.
- Illustrative ongoing annual reporting: 200-1,000 hours per hospital.
- Key costs: data extraction, contract interpretation, reconciliation, internal controls, audit documentation, software changes, and executive review.

Expanded hospital price transparency

Price-transparency rules require hospitals to maintain standardized machine-readable files and consumer-facing information. Expansion of data elements, file specifications, validation, and enforcement increases the need for continuing coordination among revenue cycle, contracting, IT, compliance, legal, finance, and data-governance teams.

- Illustrative initial implementation for major expansions: 1,000-5,000 hours.
- Illustrative ongoing maintenance: 500-2,500 hours annually.
- Hospitals must update files as contracts, charges, service codes, payer products, and technical specifications change.

FY 2027 OPPS proposed rule: major payment pressure

The FY 2027 proposed Medicare Hospital Outpatient Prospective Payment System rule would create significant payment reductions while hospitals are absorbing new reporting obligations. Public comments are due August 31, 2026.

340B drugs. Beginning January 1, 2027, CMS proposes to pay affected hospitals for separately payable drugs acquired through the 340B program at ASP minus 33.4%. Hospitals purchasing the same drugs outside the 340B program would generally continue to receive ASP plus 6%. The proposal does not add a separate amount for pharmacy overhead, handling, inventory management, compliance, or other hospital acquisition and administration costs.

Site-neutral imaging. CMS proposes Physician Fee Schedule-equivalent payment for specified imaging services without contrast furnished in grandfathered off-campus hospital departments. The policy would apply to imaging services assigned to APCs 5521 through 5524 and certain composite APCs. This expands the site-neutral approach beyond the prior focus on off-campus physician-administered drugs.

Combined operational effect

- Reduced outpatient payment can shrink the same operating margins used to fund compliance staff, cybersecurity, data systems, and quality improvement.
- Hospitals must model service-line effects, identify affected departments and claims, update budgets, educate operational leaders, and prepare comments or advocacy materials.
- 340B hospitals may need detailed pharmacy, purchasing, utilization, and compliance analyses to assess the proposed cut and its impact on safety-net services.
- Off-campus departments may need imaging-specific utilization, cost, and access analyses to quantify the site-neutral impact.

5. Two Examples of Current Significant Hospital Reporting Requirements:

Annual Form 990 and Schedule H Compliance Costs

Tax-exempt hospital organizations must file the annual Internal Revenue Service Form 990 and complete Schedule H when they operate one or more hospital facilities. This obligation is substantially more complex than an ordinary nonprofit return because it combines organization-wide financial, governance, compensation,

related-entity, tax-exempt bond, and public-disclosure reporting with hospital-specific community-benefit and Section 501(r) compliance information.

The 2025 Form 990 requires a hospital organization to complete Schedule H and attach audited financial statements. Schedule H requires reporting of financial assistance and other community benefits at cost, bad debt and Medicare information, community-building activities, management companies and joint ventures, and facility-level information. The Schedule H instructions require a hospital organization to list all hospital facilities and complete separate facility-policy sections, or permissible reporting groups, addressing community health needs assessments, financial assistance, emergency care, limits on charges, and billing and collection practices.

Principal annual work required

- Finance and accounting: reconcile audited financial statements to Form 990 revenue, expense, balance-sheet, functional-expense, compensation, related-entity, bond, and other schedule disclosures.
- Community-benefit accounting: collect direct and indirect costs, offsetting revenue, subsidized health-service data, research, education, cash and in-kind contributions, community health improvement, and community-building expenditures.
- Revenue cycle and financial assistance: validate charity-care amounts, bad debt, Medicare shortfalls, financial-assistance policy administration, amounts generally billed, and billing and collection practices.
- Facility-level Section 501(r) compliance: verify community health needs assessments and implementation strategies, emergency-care policies, financial-assistance policies, charge limitations, and reasonable-effort collection procedures for each hospital facility.
- Governance, legal, and executive review: obtain board or committee review, confirm compensation and conflict-of-interest disclosures, prepare narrative explanations, reconcile public statements, and obtain officer certification under penalties of perjury.
- External preparation and audit support: respond to questions from tax advisers, accounting firms, auditors, and e-filing vendors and retain documentation supporting all reported amounts.

Illustrative annual cost by organization type

No authoritative national study isolates the annual hospital cost of preparing Form 990 and Schedule H. The following ranges are policy-planning estimates based on the functions required, typical hospital tax and community-benefit staffing, outside professional fees, and a fully loaded internal labor rate of approximately $100-$150 per hour. They exclude the underlying cost of conducting a community health needs assessment, which occurs at least every three years, except for the annual work needed to track and report its status and implementation strategy.

Organization	Internal annual hours	Outside fees	Estimated annual cost
Small single-hospital nonprofit	250-500	$20,000-$60,000	$45,000-$135,000
Medium or large single hospital	500-1,200	$40,000-$125,000	$90,000-$305,000
Small health system (2-5 hospitals)	900-2,500	$75,000-$250,000	$165,000-$625,000
Large or complex system	2,500-8,000+	$200,000-$750,000+	$450,000-$1.95 million+

Estimated national cost

Using a broad planning assumption that approximately 2,500-3,000 nonprofit community hospitals are represented through roughly 1,500-2,000 separate Form 990 hospital filers, annual direct preparation and

compliance costs are likely on the order of $300 million-$700 million nationally. A central planning estimate is approximately $500 million per year. Over a 10-year budget window, nominal costs would be approximately $3 billion-$7 billion before inflation, or roughly $3.5 billion-$8.5 billion if annual labor and professional-service costs grow by about 3% per year.

These figures are intentionally broader than the fee charged by an outside accounting firm. The largest cost is often internal: finance, tax, community-benefit, revenue-cycle, legal, compliance, human-resources, government-relations, and executive personnel must collect, reconcile, interpret, document, and approve the information before an external preparer can complete the filing.

Potential simplification without reducing accountability

- Permit consolidated system reporting for facility-level questions when policies and practices are identical, with exceptions reported only for facilities that differ.
- Standardize community-benefit cost definitions and permit direct import from audited financial and cost-report systems.
- Eliminate duplicative questions already answered through Medicare Cost Reports, audited financial statements, provider enrollment, or publicly posted Section 501(r) documents.
- Create a secure data-reuse mechanism so unchanged policies, facility information, and identifiers are carried forward and updated only when they change.
- Coordinate any new Ways and Means reporting requirements with existing Form 990 and Schedule H fields rather than creating a parallel annual reporting architecture.
- The objective should be to preserve public accountability for tax exemption, financial assistance, community benefit, and Section 501(r) compliance while reducing repeated data collection, narrative drafting, reconciliation, and facility-by-facility duplication.

➢ Annual Medicare Cost Report Preparation and Compliance Costs

Medicare-certified hospitals generally file an annual Medicare Cost Report using Form CMS-2552-10. The filing is much more than a year-end accounting form. It requires the hospital to translate audited financial and operational data into a detailed federal cost-allocation framework covering inpatient and outpatient departments, overhead allocation, wages, utilization, uncompensated care, graduate medical education, disproportionate-share hospital calculations, organ acquisition, bad debts, related organizations, and other payment-sensitive items. The report contains nearly 30 worksheets and extensive instructions, and it is subject to desk review, reopening, audit, and settlement by the Medicare Administrative Contractor.

Principal annual work required

- Finance and reimbursement: reconcile the general ledger, audited financial statements, trial balance, patient revenue, statistics, and prior-year cost-report positions.
- Cost allocation: maintain the chart of accounts and cost-center crosswalks, classify direct and overhead costs, update allocation statistics, and reconcile departmental expenses.
- Wage and labor reporting: compile salaries, hours, contract-labor expense, occupational categories, and wage-index documentation.
- Revenue cycle and patient accounting: reconcile Medicare charges, days, discharges, bad debts, charity care, Medicaid and uninsured data, and payer-specific utilization.
- Special payment areas: prepare graduate medical education, disproportionate-share hospital, organ acquisition, rural or teaching status, provider-based department, and other applicable worksheets.
- Internal controls and certification: document assumptions, review material variances, obtain executive certification, preserve workpapers, and respond to auditor and Medicare Administrative Contractor questions.

- Post-filing activity: support desk review, furnish additional documentation, address proposed adjustments, reopen prior reports when necessary, and reconcile the final settlement to receivables and reserves.

Illustrative annual cost by hospital type

CMS publishes paperwork-burden estimates for the cost-report information collection, but those estimates do not fully capture the hospital's total internal preparation, executive review, audit support, software, consultant, and post-filing settlement work. No peer-reviewed national study isolates the complete annual cost of preparing Form CMS-2552-10. The following ranges are policy-planning estimates based on typical reimbursement staffing, the earlier 3,000-6,000-hour estimate for a 300-bed hospital, outside professional fees, and a fully loaded internal labor rate of approximately $100-$150 per hour.

Hospital or system type	Annual internal hours	Outside fees/software	Estimated annual total cost
Critical access or small rural hospital	750-2,000	$25,000-$100,000	$100,000-$400,000
Small community hospital	1,500-3,500	$50,000-$175,000	$200,000-$700,000
Typical 250-500 bed hospital	3,000-6,000	$75,000-$250,000	$375,000-$1.15 million
Academic medical center	5,000-12,000	$150,000-$500,000	$650,000-$2.3 million
Large multihospital system	10,000-35,000+	$300,000-$1.5 million+	$1.3 million-$6.75 million+

Estimated national cost and 10-year impact

Using a broad weighted-average planning cost of approximately $250,000-$650,000 across roughly 5,000 annual hospital cost reports, the direct national preparation and compliance cost is estimated at approximately $1.3 billion-$3.2 billion per year. A central planning estimate is approximately $2.2 billion annually. Over a 10-year federal budget window, the cumulative nominal hospital cost would be approximately $13 billion-$32 billion before inflation, or approximately $15 billion-$37 billion if labor, software, and professional-service costs rise by about 3% annually.

These estimates include more than the final electronic filing. They encompass year-round data maintenance, departmental reconciliation, workpaper preparation, executive review, consultant and software expense, Medicare Administrative Contractor inquiries, audit support, amendments, reopening activity, and settlement accounting. Costs vary sharply with teaching status, organ-transplant programs, rural classifications, provider-based departments, ownership complexity, and the number of payment adjustments reported.

Potential simplification without weakening payment integrity

- Prepopulate stable ownership, enrollment, facility, and prior-year data and require hospitals to report only changes.
- Permit direct import of audited general-ledger and statistical data using a standardized chart-of-accounts mapping.
- Eliminate worksheets and data elements that CMS does not use for payment, rate setting, program integrity, or public analysis.

- Align Medicare Cost Report definitions with Medicaid cost reports, Form 990 Schedule H, hospital price-transparency files, and provider-enrollment systems.
- Use risk-based audit and desk-review protocols so low-risk hospitals with clean histories face fewer repetitive documentation requests.
- Provide a single national electronic workpaper standard and consistent Medicare Administrative Contractor review guidance.
- Shift data collection to Medicare Advantage organizations when the information originates with payer contracts or remittances, rather than requiring hospitals to reconstruct it through Worksheet S-12.
- A 20%-30% reduction in avoidable preparation, reconciliation, and review work could save approximately $260 million-$960 million nationally each year, or approximately $3 billion-$11 billion over 10 years, while preserving the cost report's essential payment, rate-setting, and program-integrity functions.

6. Projected Savings from Targeted Federal Regulatory Reform

The ten reforms described below would not eliminate patient-safety, quality, privacy, emergency-preparedness, or program-integrity protections. They would primarily remove duplicate submissions, manual re-entry, repeated attestations, inconsistent definitions, overlapping audits, and process documentation that does not improve clinical outcomes.

National savings estimate

If all ten reforms were enacted and implemented substantially as described, U.S. hospitals and health systems could realize approximately $8 billion to $17 billion in recurring annual direct administrative savings once implementation is substantially complete. Using a 10-year budget window, estimated net savings are approximately $77 billion to $166 billion after transition costs, with a central estimate near $117 billion. Additional recovered clinical capacity and avoided opportunity costs could add $2 billion to $5 billion in annual economic value, although not all of that value would appear as a direct reduction in hospital operating expenses.

Measure	Estimated savings or value
Year 1 net savings after transition costs	$5B-$13B
Year 2 net savings	$8B-$16B
Year 3 net savings	$8B-$17B
Recurring annual savings after implementation	$8B-$17B annually
10-year net cumulative savings	$77B-$166B
Central 10-year estimate	Approximately $117B
Recovered clinical capacity / avoided opportunity cost	$2B-$5B annually, not all booked as expense reduction

Estimated recurring savings by reform

Federal reform	Estimated annual direct savings
Consolidate duplicative hospital quality measures	$1.5B-$2.7B
Automate clinical abstraction and establish report-once submission	$1.0B-$2.2B
Eliminate or substantially narrow Worksheet S-12	$50M-$200M
Consolidate hospital price-transparency reporting	$300M-$800M
Create one infection and public-health reporting pathway	$400M-$900M

Federal reform	Estimated annual direct savings
Simplify Medicare and Medicaid enrollment and revalidation	$150M-$400M
Reduce repetitive Conditions of Participation documentation	$3.0B-$5.8B
Streamline emergency-preparedness documentation and exercises	$150M-$400M
Coordinate federal audits and data validation	$800M-$1.8B
Modernize Stark Law and Anti-Kickback regulations	$500M-$1.5B
Rounded national range after overlap adjustment	$8B-$17B

Where the largest savings would occur

- Repetitive Conditions of Participation documentation is likely the largest opportunity. The AHA found that CoP documentation and billing/coverage verification together accounted for more than two-thirds of hospital regulatory FTEs and approximately 63% of the measured regulatory cost in the domains studied. A targeted 12%-24% reduction in the documentation component could save roughly $3.0-$5.8 billion annually.
- Quality-measure consolidation and automated data extraction could together save approximately $2.5-$4.9 billion annually. Savings would come from retiring duplicative and topped-out measures, aligning specifications and deadlines, reducing manual chart abstraction, and permitting one validated submission to satisfy multiple programs.
- Coordinated federal audits could save $800 million-$1.8 billion annually by preventing duplicate record requests and reviews, harmonizing look-back periods, and permitting a single corrective-action response where multiple contractors identify the same issue.
- Modernizing Stark and Anti-Kickback requirements could save $500 million-$1.5 billion in legal, valuation, contracting, and compliance expenses, apart from any additional clinical savings generated by easier care coordination.
- Worksheet S-12 has a smaller national dollar effect but an especially low patient-care risk if reporting responsibility is shifted to Medicare Advantage organizations, existing encounter data are used, or CMS employs statistically valid sampling.

Illustrative savings by organization type

Organization	Current estimated annual reporting/compliance cost	Potential recurring savings	Potential capacity released
Critical access hospital	$0.5M-$1.5M	$0.1M-$0.35M	1-3 FTE
Community hospital	$1.5M-$8M	$0.4M-$2.2M	3-15 FTE
Academic medical center	$8M-$20M+	$2M-$6M	12-40 FTE
Small health system	$12.5M-$41M	$3M-$11M	20-75 FTE
Large integrated system	$75M-$250M+	$18M-$65M	120-400 FTE

For the average community hospital in the AHA regulatory-burden study, which spent approximately $7.6 million annually on the federal requirements examined, the combined reforms could plausibly reduce annual costs by approximately $1.6 million to $3.1 million and release the equivalent of roughly 12 to 24 FTEs. Many hospitals would redeploy a significant share of this capacity to patient access, direct clinical care, cybersecurity, care coordination, infection prevention, and revenue-cycle improvement rather than eliminate positions immediately.

Transition costs and timing

The reforms would require temporary investments in common data standards, EHR interfaces, workflow redesign, staff training, contract revisions, parallel testing, and federal portal development. Estimated one-time hospital transition costs are approximately $2 billion to $4.4 billion nationally. Net hospital savings are projected at $5 billion to $13 billion in Year 1, approximately $8 billion to $16 billion in Year 2, and approximately $8 billion to $17 billion in Year 3. Over a 10-year budget window, total net hospital savings are estimated at $77 billion to $166 billion, with a central estimate of approximately $117 billion.

Budget-window period	Projected net hospital savings
Year 1	$5B-$13B after implementation costs
Year 2	$8B-$16B as duplicative requirements are retired and automation expands
Year 3	$8B-$17B as recurring savings approach full implementation
Years 4-10	$8B-$17B annually, subject to maintenance and policy stability
10-year cumulative	$77B-$166B net direct hospital savings; central estimate approximately $117B

How the savings would appear

- Hard-dollar savings: lower vendor, consulting, legal, temporary staffing, software-interface, audit-defense, overtime, storage, and document-production costs; selected positions may be reduced through attrition or consolidation.
- Redeployed capacity: hospitals may retain employees but redirect time from reporting and documentation to patient scheduling, nursing, care management, discharge planning, infection prevention, cybersecurity, clinical documentation improvement, and denial prevention.
- Avoided cost growth: streamlined requirements would reduce the need to hire additional quality abstractors, reimbursement specialists, analysts, data engineers, and compliance staff as new mandates are introduced.

Methodological cautions

These figures are policy-planning estimates rather than audited forecasts. The AHA baseline was developed from 2017 data and does not map perfectly to every current requirement. The Health Affairs Scholar estimate of $166.1 billion in hospital administrative expense includes necessary management, billing, finance, and human-resource functions and therefore cannot be treated as regulatory cost. Several reforms overlap, particularly quality-measure consolidation, automation, and infection reporting. Savings would also be reduced if states, accreditors, or commercial payers continued collecting information that federal agencies stopped requiring.

7. Congressional and Administrative Policy Options

- Establish a government-wide Hospital Regulatory Reporting Council and a complete inventory of federal hospital reporting obligations.
- Require common data definitions, aligned reporting calendars, and a single federal submission architecture where feasible.
- Require agencies to use existing claims, cost-report, EHR, and federal repository data before creating new hospital submissions.
- Require quantified administrative burden and clinician-opportunity-cost estimates before finalizing major mandates.
- Sunset or periodically reauthorize reporting requirements and retire measures that are duplicative, topped out, or weakly tied to outcomes.

- Harmonize Medicare and Medicaid reporting and expand certified, automated data exchange.
- Require agencies to eliminate duplicative reporting before adding new requirements and direct GAO to review cumulative federal burden.
- Assess payment reductions and new reporting mandates together so that hospitals are not required to finance increasingly complex compliance systems with simultaneously declining reimbursement.

8. More Federal Regulatory Burden on the Way

➢ New Off-Campus HOPD Attestation, Site-Specific NPI, and Billing Requirements

Section 6106 of the FY 2026 health care extenders legislation, enacted in January 2026, requires hospitals to attest to their off-campus hospital outpatient departments (HOPDs), obtain and maintain a location-specific National Provider Identifier (NPI) for each affected off-campus site, and use the new identifier on applicable claims and patient bills. The requirements take effect in January 2028. Because implementation affects provider enrollment, payer contracting, master data, claims, patient accounting, prior authorization, compliance, and billing communications, hospitals are likely to need at least one year of preparation; organizations with numerous sites or payer contracts may require substantially longer.

Operational requirements and affected functions

- Inventory and validate every off-campus HOPD, including ownership, address, services, provider-based status, enrollment records, and billing relationships.
- Prepare and submit attestations and supporting documentation for each affected location.
- Apply for or associate a distinct site-specific NPI with every off-campus HOPD and maintain accurate records as locations open, close, relocate, or change services.
- Reconfigure patient accounting, claims editing, charge description master, electronic data interchange, clearinghouse, payer-contracting, and denial-management systems so the correct location NPI appears on every applicable claim.
- Modify patient statements and billing files so the source location of care is identified consistently.
- Test Medicare, Medicaid, Medicare Advantage, and commercial-payer transactions and resolve payer-specific edits or enrollment mismatches before January 2028.
- Create ongoing controls, audits, training, and change-management procedures to prevent claims from being submitted under the wrong site identifier.

Illustrative implementation cost

No official CBO, CMS, or GAO estimate is available for the nationwide hospital cost of these requirements. The following policy-planning estimate assumes that hospitals must perform enterprise-level systems work and site-level enrollment, validation, testing, and billing conversion. Actual costs will vary with the number of off-campus sites, legacy systems, payer mix, and whether a health system can implement a common solution across multiple hospitals.

Cost component	**Illustrative cost per hospital/system**
Enterprise inventory, legal and compliance review	$75,000-$300,000
NPI enrollment, credentialing and site validation	$5,000-$20,000 per off-campus HOPD
Claims, EDI, patient accounting and statement changes	$150,000-$750,000
Payer testing, contracting and denial-prevention work	$75,000-$350,000
Training, controls, audits and project management	$75,000-$300,000
Illustrative one-time cost	$375,000-$1.7 million per hospital/system, plus site-

Cost component	Illustrative cost per hospital/system
	specific costs
Illustrative recurring annual cost	$75,000-$350,000 per hospital/system, plus $2,500-$10,000 per HOPD

National cost estimate and 10-year impact

Using a broad planning range for the number of affected hospitals and off-campus sites, the national cost could be approximately:

- Preparation and implementation year: $1.5 billion-$4.5 billion.
- First full operating year: $350 million-$1.0 billion.
- Second and subsequent operating years: $300 million-$900 million annually.
- Ten-year cumulative hospital cost: approximately $4.3 billion-$12.7 billion.

The principal cost drivers are not the NPI application itself. They are the need to create a reliable location master, reconcile provider enrollment records across payers, modify claims and billing systems, test every transaction path, update patient statements, and prevent denials caused by mismatched identifiers. Multi-state systems and organizations with numerous off-campus clinics, imaging sites, infusion centers, and physician practices would incur the largest costs.

Expert operational and patient-access analysis

An expert analysis prepared by a major health system concludes that the new location-specific NPI requirement is duplicative because hospitals already use the PO and PN claim modifiers to identify services furnished in hospital outpatient departments. The brief argues that adding another identifier would increase administrative work without materially improving transparency, claims accuracy, or payer oversight.

Prior authorization and network participation present the most immediate operational risk. Thousands of services require payer authorization tied to a contracted NPI. Each new location-specific NPI may therefore need enrollment, credentialing, contracting, and testing across Medicare Advantage and commercial payers before claims can be authorized and paid. The expert brief estimates that contracting and credentialing timelines can range from six months to three years. If an NPI is not recognized by a payer by January 2028, hospitals could experience denials, delayed surgeries and imaging, interruptions in specialty treatment, out-of-network referrals, higher patient cost sharing, and significant cash-flow pressure.

The claims-processing implications could be especially complex for patients receiving services in multiple outpatient departments during the same encounter or on the same day. Medicare currently permits one billing NPI per claim. If each HOPD-specific NPI must be reported separately, hospitals may have to split services across multiple claims unless CMS redesigns the institutional claim. Separate claims could interfere with OPPS Ambulatory Payment Classification packaging, National Correct Coding Initiative edits, and Outpatient Code Editor logic. They could also increase claims volume, create overpayment or underpayment risk, generate denials, and raise beneficiary coinsurance when services that would otherwise be packaged are unbundled.

The burden would be greatest for academic systems, multi-state systems, and hospitals operating many off-campus infusion, imaging, cancer, specialty, and ambulatory sites. These organizations often coordinate multiple same-day services for patients who travel long distances or have complex conditions. Location-specific authorizations and claims could fragment those coordinated encounters and disproportionately affect rural patients, lower-income patients, and people with complex chronic disease.

Additional cost implications

The prior cost estimate remains a reasonable planning range, but the expert analysis identifies several cost categories that could push complex systems toward the high end or above it: renegotiating or amending every affected commercial and Medicare Advantage contract; completing payer enrollment and credentialing for each location; redesigning prior-authorization workflows; modifying UB-04 and electronic claim processes; splitting

and reconciling claims when multiple HOPDs participate in one episode; reprogramming APC packaging, coding edits, and patient-liability calculations; and financing working-capital shortfalls caused by denials or delayed credentialing.

Accordingly, the estimated $1.5 billion-$4.5 billion national preparation cost and $4.3 billion-$12.7 billion 10-year cumulative cost should be viewed as a base planning range. A prolonged cross-payer credentialing process, mandatory claim splitting, or substantial denial rates could increase the true economic impact. Those secondary costs are not fully captured in the estimate because reliable national data on the number of affected NPIs, payer contracts, split claims, and delayed payments are not yet available.

Potential payment and patient effects

The requirement is intended to improve site-of-care identification and transparency. To avoid disrupting care, CMS should issue a uniform implementation guide well before 2027, establish a centralized cross-payer enrollment pathway, confirm how multiple HOPD NPIs will be represented on institutional claims, preserve OPPS packaging and coding logic, require end-to-end payer testing, and provide a transition safe harbor for good-faith hospital implementation. Congress and CMS should also evaluate whether existing PO and PN modifiers already provide the desired location transparency at materially lower cost.

➢ 5. New House Reporting Bill for Tax-Exempt Hospitals

In July 2026, House Ways and Means Committee Republicans advanced a bill imposing new and detailed reporting requirements on not-for-profit hospitals. The measure passed on party lines, with Republicans supporting and Democrats opposing. Amendments were adopted that were described as reducing burden on small and rural hospitals, but final amendment language should be reviewed before relying on the precise scope of those protections.

The bill would create a new Internal Revenue Code Section 6033A and expand annual federal return disclosures.

Major reporting provisions

- Require every tax-exempt hospital to explain how it is addressing needs identified in its most recent community health needs assessment.
- Require audited financial statements and CMS certification numbers or other Treasury-prescribed identifiers.
- Require reporting of the cost of financial assistance and the number of completed applications received, approved, and denied.
- Require large hospitals to separately report spending on quality improvement, nonclinical programming, and other Treasury-defined community benefits.
- Require high-revenue hospitals to disclose Medicare-allowable and Medicare-unallowable advertising expenses.
- Require high-revenue hospitals to report gross receipts, costs, and cost-allocation methods for each clinical service line using a standardized federal taxonomy.
- Require high-revenue tax-exempt 340B hospitals to report patient volume by coverage type, aggregate net 340B payments, and program participation and compliance costs.
- Direct GAO to estimate implementation costs and the income-tax liability the 25 highest-revenue tax-exempt hospitals would owe if taxable.

Why the bill adds administrative burden

Many requested data elements are not maintained in the form contemplated by the bill. Service-line cost allocation, separation of Medicare-allowable and unallowable advertising, 340B net-payment calculations, application disposition counts, and standardized community-benefit classifications may require new accounting policies, data systems, internal controls, audits, and legal interpretations. Even hospitals qualifying for modified requirements would face implementation, governance, and certification costs.

Estimated implementation cost of the Ways and Means reporting bill

No official CBO or GAO implementation score is available for the hospital reporting provisions described here. The following planning estimate assumes roughly 3,000 tax-exempt hospitals, with substantially higher costs for large and high-revenue systems required to develop service-line cost allocation, 340B net-payment reporting, advertising classifications, financial-assistance application tracking, audited data controls, and new federal-return workpapers. Costs include hospital labor, consultants, legal and accounting review, IT development, audit support, and recurring data maintenance. They do not include any tax liability that could arise from a separate change in tax status.

Period	**Estimated nationwide hospital implementation and compliance cost**
Year 1	$2.0B-$5.0B for systems development, data mapping, controls, legal/accounting interpretation, and initial filing
Year 2	$1.0B-$2.5B for recurring reporting, audit support, corrections, and continued system refinement
Year 3	$0.9B-$2.2B as processes stabilize but annual reporting and validation continue
Years 4-10	$0.8B-$2.0B annually, depending on Treasury definitions, audit intensity, and scope of high-revenue requirements
10-year cumulative	$9.5B-$23.7B in hospital implementation and recurring compliance costs

These estimated costs would offset a meaningful portion of the savings available from broader federal simplification. At the midpoint, the bill could impose approximately $16.6 billion in hospital compliance costs over 10 years. Congress could reduce the burden through phased implementation, standardized federal taxonomies, safe harbors for small and rural hospitals, use of existing Medicare Cost Report and Form 990 data, and reporting thresholds tied to hospital revenue and system complexity.

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