Illinois Health and Hospital Association

August 31, 2026

Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Calendar Year 2027 Hospital Outpatient Prospective Payment System Proposed Rule (CMS-1850-P)

Dear Administrator Oz:

On behalf of our more than 200 hospitals and over 30 health systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment on the calendar year (CY) 2027 Outpatient Prospective Payment System (OPPS) proposed rule. We are deeply concerned about certain proposals outlined by the Centers for Medicare & Medicaid Services (CMS), particularly as CMS payment policies continue to push hospital-level care to the outpatient setting. If finalized, these policies would negatively affect beneficiary access to hospital-level care, increase hospital regulatory burden, and lead to patient billing confusion. Specifically, we ask CMS to consider the following:

- Reassess the methodology used for rate updates under the OPPS;
- Provide hospitals with the time, flexibility and guidance necessary to prepare for the Jan. 1, 2028, statutory requirement that each off-campus hospital outpatient department (HOPD) obtain and bill under its own National Provider Identifier (NPI) and attest to compliance with provider-based requirements;
- Withdraw proposals to reduce Medicare reimbursement for 340B-acquired drugs and expedite the annual clawback of funds related to the 2018 340B reimbursement reduction;
- Consider unintended consequences that impede patient access to medically necessary healthcare when eliminating the inpatient only (IPO) list; and
- Withdraw the proposal to reduce payment for all imaging without contrast services furnished in excepted off-campus HOPDs.

Hospitals are already facing several cost pressures, including payment reductions arising from changes to Medicaid financing and the continued rising pharmaceutical, supply-chain, and workforce costs. We urge CMS not to compound these challenges through additional payment reductions and access-impeding policies.

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CY 2027 Proposed Rate Update

CMS proposed a net update of 2.4% for CY 2027 OPPS payments. IHA remains concerned about the continued inadequacy of market basket updates across Medicare PPS payment systems, particularly as other policies in recent rulemaking push more services to the hospital outpatient settings. Specifically, recent market basket updates proposed by CMS have fallen short of or failed to exceed general inflation, let alone medical inflation which outpaces general economic inflation. This year is no exception, with the proposed market basket update of 3.2% below current inflation of 3.4%[1] year-over-year as well as medical inflation which is project to hit 9% in 2027.[2] When combined with the Affordable Care Act (ACA) productivity adjustment, which continues to be inappropriately applied to the medical field, Medicare's payment updates to hospitals across care settings are increasingly deficient. We urge CMS to reassess its methodology for updating hospital payments each year, including the elimination of the productivity cut which was proposed alongside policies in the ACA that never came to fruition.

Off-Campus HOPD NPI Implementing Regulations

Under section 6225 of the Consolidated Appropriations Act, 2026 (CAA 2026), each off-campus HOPD will be required to obtain and bill under its own NPI, along with meeting new initial and subsequent provider-based attestation requirements. **We support many of CMS' proposals that would reduce burden for the attestation process. That said, we have significant concerns about the separate NPI requirement related to the increased burden it will cause for hospitals and health systems, physicians and other insurers.**

As proposed, we feel that the implementing regulations are too vague for hospitals and health systems to adequately prepare for a Jan. 1, 2028 implementation date. We are primarily asking CMS to provide additional guidance and clarity on the NPI requirement in the CY 2027 OPPS final rule. Having clear and thorough guidance by the end of the 2026 calendar year will provide hospitals with more time to complete provider enrollment changes, payer configuration and end-to-end testing and may help avoid costly delays and audits. We aim to ensure there is enough time and specific guidance to comply with CMS' requirements, and that there is sufficient oversight to ensure unintended consequences do not hinder patient access to healthcare. With this overarching framework in mind, we offer the following comments.

Additional Clarity on Which HOPD Entities Require a Unique NPI

To ensure compliance with the CAA 2026 requirements, we ask CMS to provide specificity around which entities require a unique NPI. Clarity is needed on whether the physical off-campus building requires a unique NPI, or if every clinic within that building requires a unique

[1] https://www.bls.gov/cpi/
[2] https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html

NPI. We strongly urge CMS to make the NPI requirement specific to the building, and not each individual clinic within that building.

Requiring unique NPIs for each distinct clinic within an off-campus building would significantly increase the administrative burden for both providers and CMS. We are also concerned about how long it may take to receive NPIs once guidance is provided, as recent attempts by hospitals to secure NPIs have taken upwards of two months, when historically the processing time has only been two weeks. Limiting this off-campus provider-based department (PBD) requirement to the physical building will achieve the same administrative goals while minimizing the administrative burden on the provider and the Medicare Provider Enrollment, Chain, and Ownership System.

Provide Timely Information on Risk Determinations and Appeals

In the proposed rule, CMS states it will establish criteria and methodologies used to select attestations for extended review through operational guidance, stating that it will focus on those presenting the highest risk of noncompliance with provider-based requirements. We ask that CMS provide transparency regarding this risk-based review process, with thorough guidance provided well before the unique NPI implementation date. **Providing information on the categories of risk, documentation expectations, and provider actions that will trigger a review could also be used by providers ahead of 2028 to ensure and maintain compliance.** Such proactive action on the parts of both CMS and providers would avoid unnecessary documentation, as well as preventable extended reviews or audits, ensuring neither side expends scarce resources on unnecessary administrative tasks.

Additionally, CMS should clarify the appeal rights available to providers when off-campus PBD attestation is denied, when an existing off-campus PBD is found noncompliant, or when CMS or contractors determine a location is noncompliant. Clear appeal procedures are necessary to ensure consistent national implementation and interpretation of the requirements laid out at 42 CFR § 413.65.

Finally, we urge CMS to convene stakeholders to identify and resolve claims processing issues, and to exercise enforcement discretion during this transition period for providers.

Administrative and Billing Considerations

Under the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification provisions, Congress mandated that providers obtain a single identification method, the NPI, to use across all claims, regardless of payer. The implementing regulations put forth in the CY 2027 OPPS proposed rule require distinct NPIs for use with Medicare, but do not address other payers with whom providers have established billing relationships. **Without required adoption across the healthcare industry, the use of new NPIs for Medicare may create issues with non-Medicare payers.**

Lack of guidance for non-Medicare payers may lead to billing issues such as problems with coordination of benefits, prior authorization denials, or split billing. For example, if CMS is the secondary payer on a bill received from a commercial plan and the NPIs differ by payer, there may be administrative issues that will require time and resources to resolve for a single patient stay.

Similarly, we are concerned that this policy could create prior authorization issues for providers with Medicare Advantage (MA) plans or other payers. Prior authorization is typically tied to the billing or servicing NPI. We are concerned that payers will not be prepared to review prior authorization requests that are tied to newly issued NPIs, and that there may be a deluge of unnecessary care denials that will delay patient care and increase the administrative burden of this requirement on providers.

Additionally, should a patient's care span the main campus for some services and an off-campus clinic for other services, the new NPI requirements would prevent a single patient bill as NPIs cannot be reported at the service line level of a claim. Split billing often causes patient confusion and frustration and may create otherwise avoidable administrative or coverage issues with payers.

Cumulatively, these concerns signal a need for CMS to address potential unintended billing consequences between providers, payers, and patients. We suggest that CMS consider and issue guidance to commercial payers, including Medicare Advantage plans, to ensure that they are aware of the changes being made, they adopt the unique NPI created for off-campus PBDs with which they have contracts, and they adhere to any billing changes necessary to mitigate administrative burden for providers and the patients they serve. Specifically, we suggest CMS should create a standardized mechanism that links each off-campus NPI to the hospital's main campus NPI and ensure this crosswalk is available to Medicare contractors and other payers so that systems can recognize the same hospital organization.

Attestation Form

We appreciate that the attestation form captures key provider-based requirements, providing a clear framework for organizations to attest to compliance with applicable CMS regulations. We respectfully request that CMS alter the form so that a single hospital can use one form to attest for all associated off-campus PBDs at one time. Requiring the completion of one attestation form for each off-campus PBD will be labor intensive and time-consuming both for providers to complete and for CMS and its contractors to review.

Additionally, while some of the questions throughout the attestation form include citations, most do not. Ensuring each question references the applicable CFR citation or document that outlines the requirements providers are attesting to would help ensure consistency in how facilities evaluate and respond to the attestation requirements.

We would also appreciate clarifying definitions throughout the form, including for the definition of an authorized signatory within the Signature and Certification section to specify who may execute the attestation on behalf of the organization, as well as examples of what constitutes a material change. Including examples such as ownership changes, changes in governance, relocation of services, management agreement changes, or licensure changes would provide additional clarity for respondents. Additionally, requirement 8 (geographic proximity) includes multiple exceptions and alternative qualification pathways. Additional instructions or guidance regarding the documentation needed to support these exceptions may improve consistency in completion of the attestation.

Finally, we suggest CMS add fields for the effective date of the attestation and any subsequent review dates to clarify the period for which the organization is certifying compliance.

340B-Related Proposals

CMS put forth two policies in the OPPS proposed rule related to 340B: (1) to increase the annual reduction to the OPPS conversion factor related to its CY 2018 340B reimbursement reduction from 0.5% to 3%, and (2) to pay for drugs acquired under the 340B drug pricing program at average sales price minus 33.4%. We agree with the American Hospital Association's analysis: both proposals suffer legal defects and refer CMS to their comment letter.

CMS' proposal to accelerate the clawback of funds remains unlawful and should not have been finalized. **If CMS is going to revisit this decision, it should rescind the clawback altogether because CMS lacks the statutory authority for any clawback on any timeline. However, should CMS persist with this clawback, it should not finalize the acceleration proposed in this rule.** This would be the third different timeline proposed by CMS for the purpose of recouping OPPS payments in the last four years, creating ongoing uncertainty for hospitals that are facing myriad financial pressures, ongoing workforce challenges, and increased regulatory burden from both federal and state governments.

With this proposed acceleration, CMS is ignoring its own rulemaking. CMS finalized a clawback in 2023 under "*Medicare Program; Hospital Outpatient Prospective Payment System: Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022*," 88 Fed. Reg. 77,150, 77,179 (Nov. 8, 2023). In that rule, CMS stated the clawback was designed to "comply with statutory budget neutrality requirements while at the same time accounting for any reliance interests and ensuring that the offset is not overly burdensome to the impacted entities." Now CMS explains it is changing course to "restore affected 340B covered entity hospitals to the financial position they would have been in had the 340B Payment Policy not been implemented in 2018." This change calls into question the "budget neutrality requirements" cited in the 2023 final rule and instills doubt in the validity of the notice and rulemaking process for our hospital and health systems.

CMS also should not finalize its proposal to cut reimbursement rates for 340B-acquired drugs by nearly 40%. CMS' proposal is based on an invalid cost acquisition survey. There are legal requirements at 42 U.S.C. § 1395l(t)(14)(D)(iii) which CMS must meet to deem a survey valid, and as the AHA explains, CMS failed to meet the required criteria.

These two policy proposals are on top of a series of policy decisions HHS has made that impose significant costs on 340B hospitals, including the 340B Rebate Program and continuing to allow pharmaceutical manufacturers to impose unlawful, onerous and expensive claims and data requirements on hospitals. Each of these actions on their own undercuts the purpose of the 340B program, but cumulatively they make it difficult for safety net and other 340B hospitals to justify participating in this program at all. This is especially concerning considering that 340B was designed to help compensate providers serving a disproportionate share of low-income patients for the inadequate reimbursement provided under the Medicare and Medicaid programs.

Illinois' 340B hospitals have reported to IHA that if these policy proposals are finalized, they will be forced to cutback important service lines, close some expensive service lines altogether, and consider integrating with more financially stable hospitals. In fact, one rural Illinois 340B hospital explained that they are only able to offer chemotherapy services because of the 340B program. Should this reimbursement cut be finalized, they may have to close their oncology clinic, requiring patients to travel tens of miles to access their chemotherapy and other oncology treatments. This is just one example of how Illinois hospitals reinvest 340B savings into their facilities and communities to improve access to medically necessary healthcare.[3]

Elimination of IPO List

IHA continues to strongly oppose CMS' planned elimination of the IPO list. The IPO list was created to protect beneficiaries, and many of the services on the IPO list are complicated and invasive surgeries. These services may involve multiple days in the hospital, special protections against infections, and significant rehabilitation and recovery periods, requiring the care and coordinated services of the inpatient setting of a hospital.

We understand CMS intends for the removal of the IPO list to increase patient and provider choice, but we are concerned that this policy will be accompanied by unintended consequences that may delay access to care. Specifically, payers, including government payers, Medicare Advantage plans, and commercial insurers, are increasingly turning to utilization management practices, like prior authorization, to lower the cost of healthcare. **Utilization management practices have gotten out of hand, jeopardizing the ability of physicians to use their specialized training and knowledge to make the best decisions about patients' medical needs. We are concerned that eliminating the IPO list will increase the use of utilization management, impeding healthcare access and delaying medically necessary care.**

[3] https://team-iha.org/advocacy-policy/340b/

That said, we are supportive of providing the right service at the right location, and the historically utilized process for removing a procedure from the IPO list fosters this principle. This removal process considers important factors like average length of stay, peer-reviewed evidence, and patient factors, such as comorbidities and age. These same considerations are often ignored by payers, requiring providers to spend time and money appealing prior authorization denials in pursuit of the care their patients need. Therefore, instead of eliminating the IPO list, IHA recommends that CMS continue its standard process when considering the appropriate removal of procedures from the IPO list. This process is designed to consider new technologies, advancement in medical knowledge, and improvements in care delivery, while maintaining physician autonomy and preserving the physician-patient relationship.

Should CMS insist on moving forward with the elimination of the IPO list, we strongly encourage CMS to work with Congress to secure additional guardrails around payer use of utilization management. Illinois providers have already expressed concern with the lack of adequate CMS oversight of Medicare Advantage plans, which have a documented history of inappropriately denying medically necessary prior authorization requests.[4,5,6] Market penetration of MA plan participation continues to grow, as does patient confusion over covered services, cost-sharing, and the overall cost of care. **The frustrating and life-threatening care delays that MA-enrolled beneficiaries are experiencing today will only get worse unless CMS secures a more intentional and substantive oversight and compliance role.**

Site Neutral Payment for Imaging without Contrast Services

IHA opposes CMS' proposal to reduce payment for imaging without contrast services furnished in excepted off-campus HOPDs to the site-neutral rate of 40% of the outpatient PPS rate. **We urge the agency to withdraw this proposal from consideration.**

CMS cites increased volume of imaging without contrast services in HOPDs as its primary rationale for proposing this site-neutral payment policy. We disagree that higher payments for imaging services in HOPDs are incentivizing hospital acquisition of independent physician offices. There are many factors that have led physicians to abandon private practice and seek employment in HOPDs, including inadequate payments from Medicare, Medicaid and private payers, as well as excessive administrative burdens.[7,8,9]

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[4] https://oig.hhs.gov/reports/all/2026/the-three-largest-medicare-advantage-organizations-denied-requests-for-long-term-acute-care-and-inpatient-rehabilitation-at-some-of-the-highest-rates/
[5] https://oig.hhs.gov/reports/all/2026/medicare-advantage-organizations-overturned-nearly-all-appealed-prior-authorization-denials-for-skilled-nursing-facility-admission-raising-concerns-about-initial-denials/
[6] https://oig.hhs.gov/reports/all/2018/medicare-advantage-appeal-outcomes-and-audit-findings-raise-concerns-about-service-and-payment-denials/
[7] https://www.aha.org/system/files/media/file/2023/06/fact-sheet-examining-the-real-factors-driving-physician-practice-acquisition.pdf

CMS also does not adequately demonstrate that its comparison of Ambulatory Payment Classifications payments to PFS payments provides an appropriate basis for imposing site-neutral payment reductions. CMS cites payment differences between HOPDs and physician office settings to support its proposal. But the differential in these rates is driven by the differences in resource use, total spending, beneficiary cost sharing and obligations associated with furnishing care in an HOPD vs. a private physician office. OPPS payments are based on hospital cost data that are submitted annually and include packaged items, services, supplies and supportive resources needed to furnish outpatient care. By contrast, PFS rates are based on relative value units (RVUs) for physician work, practice expense and malpractice expense, which are determined in part by using survey data over which CMS has expressed concerns regarding accuracy, representativeness and reliability. The calculation of PFS rates is not designed to reflect the broader operational, regulatory, staffing, standby-capacity and infrastructure requirements of HOPDs.

In other words, comparing payment rates for a single imaging procedure across the two systems does not provide a complete picture of relative resource use or total episode costs. CMS has not presented sufficient analysis showing that these payment differences reflect excess program spending rather than legitimate differences in patient complexity, service mix, emergency preparedness, compliance obligations, care coordination and hospital-based resources.

The agency also did not take into consideration that HOPDs are more likely to serve Medicare patients who are sicker, more clinically complex, and more likely to be disabled or living in poorer, rural communities than patients treated in independent physician offices.[10,11] The reality is, as Americans age, it is more important than ever that Medicare payments adequately support providers so that patients requiring more complex care have access to facilities that can provide it. Site-neutral payments like the one proposed in this rule will eventually lead to service or hospital closures, making it even more difficult for not only Medicare beneficiaries but all patients to receive the care they need.

In fact, one of Illinois' health systems recently opened an imaging center in a rural market. This brings imaging services to communities that have historically been healthcare deserts, requiring patients to drive long distances to receive imaging services. CMS' proposed reimbursement cut is concerning as this system looks at long term plans for their rural imaging center. Simply put, they may not be able to afford to keep the clinic open if these cuts are finalized, requiring

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[8] https://www.ama-assn.org/press-center/press-releases/medicare-trustees-warn-payment-issue-s-impact-access-care

[9] https://www.aha.org/news/blog/2025-10-21-physician-practice-acquisitions-what-drives-them-and-implications-consumers-and-payers

[10] "Comparison of Care in Hospital Outpatient Departments and Independent Physician Offices among Cancer Patients Updated Findings for 2019-2024", KNG Health Consulting, LLC, September 2025

[11] "Comparison of Care in Hospital Outpatient Departments and Independent Physician Offices: Updated Findings for 2019-2024", KNG Health Consulting, LLC, September 2025

patients to drive much further to an urban healthcare center for imaging services in the future, versus right down the street.

These are the types of access issues site-neutral payment policies will generate, and we urge the agency to withdraw this and future unsubstantiated site-neutral payment proposals from consideration.

Payment for Diagnostic Radiopharmaceuticals

Illinois hospitals appreciate CMS' policy to pay separately for any diagnostic radiopharmaceutical with a per day cost greater than a determined threshold, which is proposed at $665 per day for CY 2027. We also appreciate CMS' acknowledgement that an Average Sales Price (ASP) methodology for diagnostic radiopharmaceuticals would be preferred. We urge CMS to set separate payments for advanced diagnostic radiopharmaceutical drugs based on an ASP methodology, and encourage CMS to issue guidance on ASP reporting in its final CY 2027 OPPS rule as well as establish reporting requirements.

Ensuring predictable and adequate payment for diagnostic radiopharmaceuticals would help hospitals, outpatient departments, and physicians provide these services to their patients more efficiently and effectively. Stability and consistency in the payment methodology are important because diagnostic radiopharmaceuticals support advanced imaging that can help clinicians identify diseases earlier, choose appropriate treatment, and avoid unnecessary delays for patients.

CMS has already taken an important step by recognizing that higher-cost diagnostic radiopharmaceuticals warrant separate payment, but more can be done to ensure Illinoisans have greater access to care. Establishing payment based on ASP would provide Medicare beneficiaries with more timely access to innovative diagnostic technologies by giving providers greater certainty around reimbursement. It also offers a practical and familiar reimbursement standard, as ASP is already used in OPPS for other separately payable products.

RFI: Strengthening the Standardization and Comparability of Hospital Price Transparency Data

Illinois hospitals have long supported price transparency initiatives that provide meaningful, actionable data to patients. The machine-readable files (MRF) were meant to provide access and convenience to patients but have instead presented numerous challenges as the hospital field and CMS have jointly pursued data and technical uniformity. Further, maintaining compliance costs hospitals tens of thousands of dollars per year in consultant fees and staff resources. Thus, we believe CMS should focus on improving existing transparency tools, particularly price estimator tools, rather than expanding reporting requirements or increasing administrative burden.

We continue to believe that the best source of insured patient healthcare costs is the payer. For uninsured or underinsured patients, Illinois hospitals follow strict and generous financial assistance policies, as well as the good faith estimate requirements under the No Surprises Act, to provide meaningful cost information. Healthcare consumers are best served through the price estimator tools and payer comparison tools that hospitals and payers have already created. These tools translate hospital and payer transparency data into personalized estimates and increasing the size of or further complicating the already large, static machine-readable files behind these tools will not translate into increased understanding on the part of the patient.

In terms of what hospitals have for insured patients, allowed amount reporting is the most meaningful transparency data. Allowed amount transparency data provide the clearest picture of actual reimbursement, especially compared with hospital charges which are largely meaningless to insured individuals. While cost-sharing information is still necessary for a more exact cost estimate, allowed amounts will give patients the information they need to compare against the cost-sharing laid out by their individual plan.

Regarding the machine-readable file, we suggest CMS establish a standardized reimbursement data dictionary and formatting conventions for algorithm descriptions so that common contract concepts are communicated consistently while remaining machine-readable. Enhancing algorithm descriptions, as well as allowed amount reporting, rather than continually expanding the MRF with new reporting fields, provides the best path forward for improving the meaningfulness of hospital price transparency information for consumers and researchers.

Finally, though CMS did not ask, we have a suggestion for the compliance process CMS follows. Every year CMS releases a list[12] of hospitals across the country that are not compliant with the hospital price transparency regulations. Our experience in Illinois is that hospitals on the list work with CMS' notice and corrective action plan process to come into compliance. However, CMS does not update or reissue the list to reflect hospitals that come into compliance, leading patients and local news media outlets to believe that their local hospitals are actively working to obfuscate hospital pricing when in fact the opposite is true. We ask CMS to reconsider how it communicates noncompliance, and suggest the agency keep their website updated not only with dates at which hospitals are noncompliant but also dates when hospitals come back into compliance. Illinois hospitals work hard to deliver high-quality care to their communities, and it is unfortunate that outdated information creates trust issues between hospitals and the patients they serve.

[12] https://www.documentcloud.org/documents/28220113-hospitals-warned-about-providing-more-pricing-information/

RFI: Domestic Procurement of PPE and Essential Medicines

As in past comment letters, IHA appreciates CMS' efforts to support a more reliable and resilient supply chain for personal protective equipment (PPE) and essential medicines. However, we continue to have concerns about CMS' persistent pursuit of wholly domestically produced supplies of PPE and essential medicines. Simply put, American manufacturers cannot fully supply hospitals and health systems with the PPE and essential medicines necessary to support America's healthcare system. And hospitals and health systems should not be financially disincentivized from pursuing the supplies they need to serve their patients. **The onus of fixing the healthcare supply chain should not be put on hospitals, and suggesting hospitals should procure more expensive PPE and medicines is counterintuitive to this Administration and Congress wanting hospitals to play a significant role in making healthcare more affordable.**

The United States' healthcare industry relies on a global supply chain to obtain the resources necessary to meet the healthcare needs of Americans. Some products are domestically manufactured, while others are wholly or partially created overseas. In fact, data from the American Hospital Association show that nearly 70% of medical devices marketed in the U.S. are manufactured exclusively overseas.[13] This is for myriad reasons, including the reality that certain products are primarily sourced from a single supplier, country, or region. But it is also based on efficiencies, with certain countries or economies better positioned to manufacture certain healthcare supplies compared to others.

For example, the production of single-use disposable exam gloves primarily occurs in Asian countries, including Malaysia and China.[14] These countries can produce exam gloves at a lower cost as they have better access to nitrile butadiene rubber, the raw material utilized in the manufacturing of exam gloves, but also less expensive manufacturing processes due to differences in environmental regulations.

Additionally, we know that domestically manufactured healthcare supplies are not impervious to disruption. For example, in Sept. 2024, Hurricane Helene damaged a North Carolina plant that manufactured critical IV fluids, leading to shortages for more than 86% of U.S. healthcare providers. Luckily, the manufacturer had the ability to ship IV fluids into the United States from international facilities, providing relief while repairs were made to the North Carolina-based plant. [15]

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[13] https://www.aha.org/testimony/2025-05-14-aha-senate-statement-trade-critical-supply-chains#_ftn1

[14] https://research.hktdc.com/en/article/MTk2MTM0MDkwMg#:~:text=Malaysia%20could%20capture%20an%20additional,Chinese%20gloves%20made%20up%2042%25

[15] https://www.reuters.com/business/healthcare-pharmaceuticals/baxter-begins-importing-iv-solutions-facilities-outside-us-2024-10-14/

These are just two examples that demonstrate the complexity of the healthcare supply chain, and why policies incentivizing hospitals to mostly or solely purchase domestically-produced PPE and medicines should be approached with caution. While a mostly domestic healthcare supply chain may protect the American healthcare system from disruptions caused by political upheaval, it will not completely safeguard our country from other factors that can disrupt manufacturing. Any policy that might disturb hospital and healthcare provider operations should be pursued thoughtfully and with robust consideration for unintended consequences.

Administrator Oz, thank you again for the opportunity to comment on this proposed rule.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association