American Hospital Association™
Advancing Health in America

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May 12, 2025

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

Honorable Russell T. Vought
Director
Office of Management and Budget
725 17th Street NW
Washington, DC 202503

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

RE: Request for Information: Deregulation (FR Doc. 2025-06316)

Dear Secretary Kennedy, Administrator Oz and Director Vought:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, we applaud you for seeking recommendations on how to free the health care system from burdensome administrative requirements that prevent Americans from accessing the care they need to live their healthiest lives.

The Trump administration has rightly pointed out that the health status of too many Americans does not reflect the greatness or wealth of our nation. Excessive regulatory and administrative burdens are a key contributor, as they add unnecessary cost to the health care system, reduce patient access to care and stifle innovation.

For example:

- More than a quarter of all health care spending goes to administrative tasks — topping more than $1 trillion annually.[1] Providers, in particular, face excessive costs to check patients' eligibility for coverage, bill for payment, and process prior authorizations and appeals of coverage denials.
- Hospitals and health systems spend billions of dollars annually just on collecting and submitting quality measures, with one survey estimating annual per-hospital costs of $3.5 to $12 million.[2,3] The physicians with whom hospitals partner in delivering high-quality care face similarly daunting costs, with physicians in just four specialties — general internal medicine, family medicine, cardiology and orthopedics — spending an estimated $15.4 billion annually on quality measurement.[4]
- Prior authorization requests reached nearly 50 million in 2023 for Medicare Advantage beneficiaries alone, an increase from 42 million in 2022.[5]
- Most claims initially denied by insurers (70%) are ultimately paid, meaning a significant amount of administrative cost is a complete waste.[6]
- The Centers for Medicare & Medicaid Services (CMS) regulations restrict the ability of certain advanced practice providers to independently practice more than is allowable in some states, which are responsible for clinician licensure and scope of practice.

Addressing unnecessary administrative burdens and costs would go a long way to not only lower health system costs but support the accessibility of care. Many hospitals are financially unstable, with nearly 40% operating with negative margins.[7] This has led to

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[1] "Active steps to reduce administrative spending associated with financial transactions in US health care," Sahni, N., et. al., Health Affairs Scholar, Volume 1, Issue 5, November 2023, qxad053, https://doi.org/10.1093/haschl/qxad053
[2] "The volume and cost of quality metric reporting," Sarawasthula A et al. Journal of the American Medical Association. Volume 329, Number 21. June 6, 2023. 1840-1847.
[3] "Observations from the field: Reporting Quality Metrics in Health Care." Dunlap NE et al. National Academies Press; 2016. https://nam.edu/wp-content/uploads/2016/07/Observations-from-the-Field-Reporting-Quality-Metrics-in-Health-Care.pdf
[4] "US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures." Casalino LM et al. Health Affairs. Volume 35, Number 3. March 2016.
[5] https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/
[6] https://premierinc.com/newsroom/policy/80-premier-members-call-for-medicare-advantage-changes-to-address-payment-denials-and-delays
[7] https://www.kaufmanhall.com/insights/thoughts-ken-kaufman/implications-national-hospital-flash-report-hospital-operations

closures of services and even entire hospitals, and the resulting loss in access to care is felt by entire communities.

The AHA, therefore, enthusiastically shares its top 100 ways that the administration could reduce the burden on hospitals and health systems. To put together this list, the AHA collected more than 2,700 ideas from an AHA member survey. Hospitals across the country, along with our Board of Trustees and other member advisors, identified outdated, burdensome, duplicative and expensive regulations that do not improve quality and patient safety and, in some cases, impede hospitals' ability to offer the highest quality, most efficient care. Many of the items here also would remove administrative complexity to ensure that health care workers spend their time on patients, not paperwork. Some of these suggestions will require partnership with Congress, but many will not. Enacting even half of them would make a real difference throughout the health care system.

Our recommendations are grouped into four categories:

- Billing, Payment and Other Administrative Requirements.
- Quality and Patient Safety.
- Telehealth.
- Workforce.

While the full list is attached, below are the top actions we urge the administration to consider in each area.

BILLING, PAYMENT AND OTHER ADMINISTRATIVE REQUIREMENTS

Research estimates that between 25-30% of all health care spending goes toward administrative tasks, not patient care.[8] These tasks include verifying patients' insurance and coverage status, conducting prior authorizations, and acquiring and managing the personnel and technology to comply with different payment models and payer requirements. To reduce billing and payment-related burden, we recommend the following.

Make all Center for Medicare and Medicaid (CMMI) models voluntary, and specifically the Transforming Episode Accountability Model (TEAM) (42 CFR 512.5) and repeal the mandatory Increasing Organ Transplant Access (IOTA)

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

Model (42 CFR 512.412) and the Inpatient Rehabilitation Facility (IRF) Review Choice Demonstration. While we strongly support innovation to improve the quality and accessibility of health care at lower costs, some of the CMMI models, as designed, could have an immediate detrimental impact on the quality of care or on patients' access to care by overburdening their providers.

The IOTA Model is a complex mandatory payment model that purports to test whether hospital performance-based incentive payments will increase access to kidney transplants; however, these payments are designed to incentivize volume, not quality, and, in doing so, could lead to lower quality transplants and thus a higher risk of failure.

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

Finally, under the IRF Review Choice Demonstration, IRFs will have 100% of their Traditional Medicare claims subject to unnecessary and onerous pre- or post-claim review for at least six months. This will add considerable staffing costs to providers who are already struggling under rising input costs and unstable revenue.

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

Standardize more insurance-related administrative transactions, starting with operationalizing the Interoperability and Prior Authorization Final Rule (CMS-0057-F) to establish standard electronic prior authorization processes in Medicare Advantage, the Health Insurance Marketplaces and Medicaid. Hospitals often have

hundreds if not thousands of contracts with different insurance plans. Each of these plans include different rules and processes, including the way to communicate requests and share associated documentation with plans (e.g. phone, fax, proprietary portal), the services that are subject to prior authorization, and the clinical criteria a plan will use to adjudicate prior authorization and coverage requests, among other things. There is tremendous opportunity to streamline many of these rules and processes to both improve patient's access to care while also reducing the costs and burden on providers associated with compliance. For example, prior authorization is frequently applied inappropriately in ways that delay care and harm patients. CMS has taken significant steps to move many health plans towards standardized electronic prior authorization processes. These rules are intended to go into effect in 2026 and 2027, and we urge the administration to ensure robust and timely implementation.

QUALITY AND PATIENT SAFETY

High-quality, safe care is the core of hospitals' missions. While many regulations originated out of an interest to improve care quality or patient safety, those same regulations, over time, have often become obsolete or redundant. Hospitals and health systems spend billions of dollars annually just on collecting and submitting quality measures, with one survey estimating annual per-hospital costs of $3.5 to $12 million.[9,10] The physicians with whom hospitals partner in delivering high-quality care face similarly daunting costs, with physicians in just four specialties — general internal medicine, family medicine, cardiology and orthopedics — spending an estimated $15.4 billion annually on quality measurement.[11] To reduce burdens related to quality measurement and reporting, we recommend the following.

Repeal outdated COVID-19 reporting mandates. As noted above, data reporting is an incredibly time intensive activity that pulls clinicians away from patients and costs a considerable amount in both staff time and technology to complete. While we are deeply committed to ensuring the highest quality care — which requires evaluating performance and acting on the findings — it is imperative that we direct our limited resources to the highest impact areas. Unfortunately, hospitals are subject to significant outdated reporting requirements, in particular with respect to the COVID-19 public health emergency. Eliminating this unnecessary reporting would reduce costs in the health care system and enable providers to spend more time with their patients. Our

[9] "The volume and cost of quality metric reporting," Sarawasthula A et al. Journal of the American Medical Association. Volume 329, Number 21. June 6, 2023. 1840-1847.
[10] "Observations from the field: Reporting Quality Metrics in Health Care." Dunlap NE et al. National Academies Press; 2016. https://nam.edu/wp-content/uploads/2016/07/Observations-from-the-Field-Reporting-Quality-Metrics-in-Health-Care.pdf
[11] "US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures." Casalino LM et al. Health Affairs. Volume 35, Number 3. March 2016.

immediate recommendation is to eliminate the requirements for post-acute care providers to report COVID-19 vaccine rates for patients/residents and staff (86 FR 42489, 86 FR 45446, 86 FR 42396, 88 FR 51009, 88 FR 53233, 88 FR 59250, 88 FR 77767), for hospitals to report staff COVID-19 vaccination rates (86 FR 45382), and for hospitals and skilled nursing facilities 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 (42 CFR 482.42(e), 42 CFR 483.90(g), 42 CFR 485.426(e) and 42 CFR 485.640(d)).

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

Eliminate duplicative "look back" validation surveys of accrediting organizations (AOs) at 42 CFR 488.9 and permanently adopt concurrent validation surveys. As part of its oversight process, CMS conducts a full re-survey of hospital compliance with Medicare Conditions of Participation on a representative sample of hospitals each year, comparing each hospital's results with the most recent accreditation surveys. Instead of fulfilling CMS' goal of assessing AO performance, the validation surveys result in rework and disruption for hospitals and health systems. CMS should instead permanently adopt concurrent validation surveys that would allow the agency to directly observe AO performance.

Resume conducting low-risk complaint surveys virtually. During the COVID-19 pandemic, CMS adopted a policy in which accrediting organizations and state survey agencies could conduct complaint surveys of low-risk quality issues virtually. Since then, CMS has instructed AOs to conduct most complaint surveys in person, regardless of severity, and hospitals incur costs for each AO visit. Virtual surveys for low-risk complaints would enable more efficient use of survey resources and reduce administrative costs.

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 the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Despite regulatory changes in the past several years, 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). Specifically, the regulations require the separation of records pertaining

to SUD information, which prevents the integration of behavioral and physical health care because the patient data cannot be used and disclosed like all other health care data.

TELEHEALTH

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

Remove telehealth originating site restrictions within the Medicare program at Sec. 1834(m)(4)(C)(ii)(X) of the Social Security Act (42 U.S.C. 1395m) and 42 CFR 410.78(b)(3) to enable patients to receive telehealth in their homes. Under current rules, patients must be in a clinical site of care, which completely undermines the value of telehealth for patients, limits its adoption and adds costs for providers.

Remove telehealth geographic site restrictions within the Medicare program at Sec. 1834(m)(4)(C)(i) of the Social Security Act (42 U.S.C. 1395m) and 42 CFR 410.78(b)(4) to enable beneficiaries in non-rural areas to have the same access to virtual care as those in rural areas.

Remove the in-person visit requirements for behavioral health telehealth at Sec. 1834(m)(7) of the Social Security Act (42 U.S.C. 1395m) and 42 CFR 410.78(b)(3)(xiv), which is unnecessary, adds a barrier to access and creates a disparity between physical and mental health services.

Remove requirements at Sec. 3132 of the Affordable Care Act (42 U.S.C. 18001 et. seq.) and 42 CFR 418.22(4) that require hospice recertification to be completed in person to allow for hospice recertification to be completed via telehealth. This change would alleviate the burden on patients and their caregivers, as well as on clinicians.

WORKFORCE

The health care system’s greatest asset is our workforce. Unfortunately, doctors, nurses, technicians and others are increasingly burned out and leaving the profession, often citing excessive administrative burden that pulls them away from patient care. We recommend the following.

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

Eliminate the telehealth physician home address reporting requirement, which is currently under waiver as referenced at 89 FR 97110. Without continued waivers or removal, telehealth providers must list their home address on publicly available enrollment and claims forms when performing telehealth services from their homes, compromising their privacy and safety.

Eliminate nurse practitioner and other advanced practice practitioner (APP) limitations at 42 CFR 485.604(a)(2), 42 CFR 485.604(b)(1)-(3), and 42 CFR 485.604(c)(1)-(3). These regulations impose limits on the scope of care APPs may provide that are often more restrictive than under state licensure, despite states having primary responsibility for clinical scope of practice rules. In these cases, hospitals and health systems are constrained in their ability to increase patient access to care through the greater use of APPs.

Remove requirements at 42 CFR 410.61 that require outpatient physical therapy plans of care to be signed off by a physician or non-physician practitioner every 90 days. While CMS made an exception to the treatment plan signature requirement in the calendar year 2025 Physician Fee Schedule for initial care plans where there is a signed referral, the requirement for physicians to sign and date plans of care every 90 days creates an additional administrative burden.

Our attached recommendations also identify ways in which the administration can help reduce burdens caused by private sector stakeholders. While significant consolidation in the insurance industry exists, each insurer can offer thousands of unique health plan configurations, each often with its own rules and processes, such as which services are covered and the clinical criteria used to determine coverage. While we support the innovation and choice that these private entities bring to the health care system, this level of variation creates a tremendous amount of burden on providers. Fortunately, there are actions the administration can take to ease the cost and burden on providers of working with these payers, including addressing insurer consolidation that has given these companies the ability to unilaterally impose considerable burdens on providers.

Thank you for your consideration. We look forward to working with the administration on the much-needed effort to reduce regulatory red tape so that America’s hospitals and

health systems can best support the health of their communities. Please contact me if you have questions, or feel free to have a member of your team contact Ashley Thompson, AHA's senior vice president for policy analysis and development, at (202) 626-2688 or athompson@aha.org.

Sincerely,

/s/

Rick Pollack
President and CEO

Attachment: 100 Ways to Free Hospitals from Wasteful and Burdensome Administrative Requirements to Provide the Highest Quality, Most Efficient Care to Patients

100 Ways to Free Hospitals from Wasteful and Burdensome Administrative Requirements to Provide the Highest Quality, Most Efficient Care to Patients

BILLING, PAYMENT AND OTHER ADMINISTRATIVE REQUIREMENTS

Research estimates that between 25% and 35% of all health care spending is on administrative tasks, with billing and collections, which include coverage and eligibility verification, being one of the costliest areas. The following changes could dramatically lower administrative costs; many would also improve patient access to care.

Interactions with Health Plans

1. Eliminate duplicative and costly billing infrastructure within hospitals, health systems and other providers by shifting cost-sharing collection responsibilities to insurers — the entities that set co-pay, deductible and co-insurance amounts.
2. Reduce variation in prior authorization processes by enforcing the interoperability and prior authorization final rule, which will streamline electronic prior authorization processes across many payers.
3. Eliminate billions in excess health care system costs, resulting from providers chasing payment from insurers, by establishing prompt pay requirements in all forms of health care coverage, including Medicare Advantage.
4. Implement a standardized claims attachment to allow plans to request and providers to transmit necessary medical records via a safe electronic transmission standard.
5. Reduce the time providers waste tracking down the unique criteria that each Medicare Advantage plan uses to adjudicate claims by establishing a single clinical standard for both Traditional Medicare and Medicare Advantage.
6. Reduce the time patients spend waiting for post-acute care placements by disallowing plans from implementing prior authorization requirements for these services in certain circumstances.
7. 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.
8. Remove requirements for payers and plans to have separate credentialing processes and allow for payers to instead recognize hospital credentialing.
9. Adopt a standard process for providers to appeal a Medicare Advantage plan denial of a prior authorization request or claim.

10. 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").
11. Establish and enforce network adequacy requirements for post-acute care on Medicare Advantage plans to enable patients to begin necessary post-acute care as timely as possible while freeing up inpatient capacity.
12. Improve the flawed and cumbersome No Surprises Act Independent Dispute Resolution process while retaining the patient protections against surprise billing to allow insurers and out-of-network hospitals and health systems to work together more efficiently to determine appropriate reimbursement.
13. Remove the prior authorization requirement for non-emergent Veterans Affairs community care network services, which requires providers to submit a form that takes at least three days to process, therefore unnecessarily delaying care.
14. Expand access to alternative coverage options for employees, such as through Individual Reimbursement Arrangements, which would reduce the administrative burden on employers.

Information Technology and Coding

15. Repeal the excessive and confusing "information blocking" rule that would impose unjustified penalties on providers.
16. Modify the HIPAA cybersecurity rule of December 2024 to make the requirements voluntary.
17. Modify the HIPAA Breach Notification Rule to remove the requirement to report breaches affecting fewer than 500 individuals.
18. Eliminate billing and coding requirements for psychiatric care at 42 CFR 483.102 as they are overly stringent and not based on medical criteria.
19. Streamline the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) code sets to standardize reporting across all payors.
20. Eliminate unique HCPCS codes for generic drugs, which adds burden by complicating the billing process.

Administrative and Regulatory Barriers to Care

21. Repeal the Food and Drug Administration Laboratory Developed Tests final rule that will hamper hospital labs' ability to continue developing high-quality in-vitro tests that have increased access to care and reduced costs.

22. 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 health care can get the most effective care efficiently.
23. Similarly, repeal the 180-day lifetime limit on inpatient psychiatric facility services under Medicare.
24. Allow inpatient rehabilitation facilities (IRFs) to care for more than just inpatient rehabilitation patients when capacity is an issue (such as during a pandemic), which could reduce patient wait times for care.
25. Eliminate the observation hours "carve-out" policy for diagnostic or therapeutic services.
26. Simplify the detailed and complex reporting process of the Medicare Cost Reports.
27. Modernize the Stark Law and Anti-kickback Statute regulations to better protect arrangements that promote value-based care.
28. Repeal the requirement that Critical Access Hospital (CAH) based ambulance services only receive cost-based reimbursement if they are the sole ambulance provider within 35 miles. Instead, all CAH-based ambulance providers should receive cost-based reimbursement.
29. Modify Environmental Protection Agency project building timelines that significantly delay the construction of new sites of care.
30. Expand hospitals' ability to utilize swing beds.
31. 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

32. 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.
33. 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.
34. 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.
35. Eliminate the skilled nursing facility three-day length of stay requirement that often delays patients from transitioning to the most appropriate site of care.

36. Simplify and expedite discharge processes by removing the requirement that hospitals provide patients with a list of post-acute care (PAC) providers from which to select when hospitals already work with patients and PAC providers for appropriate placement.
37. 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.
38. Eliminate the requirement that a hospital operate for at least six months under the prospective payment system before converting to CAH status.
39. 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.
40. Allow for exceptions to the requirement that Medicare overpayments are returned in 180 days, given that providers may need additional time to complete investigations.
41. Allow Medicare bad debts to be written off as contractual allowances, which is consistent with standard accounting practices and was permitted under prior policies.
42. 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.
43. Standardize coverage, coding and billing criteria among Medicare Administrative Contractors (MACs).
44. Remove the restriction that disallows hospitals from choosing a different MAC.
45. Streamline the Medicare appeals process to allow uploading of medical records at the time of claim filing.
46. 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.
47. Rescind Centers for Medicare and 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.

48. 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.
49. Strengthen Medicare-dependent and Sole Community Hospitals by allowing participating hospitals to choose from an additional base year when calculating payments.

Price Transparency

50. Eliminate the convening provider requirement as part of good faith price estimates given to patients, because there is no technical solution to operationalize it.
51. Create a more streamlined and accurate process for patients to access pricing information by having insurers serve as the "source of truth" by publishing the negotiated rates and requiring hospitals to post cash price and chargemaster rates.

QUALITY AND PATIENT SAFETY

High-quality, safe care is the core of hospitals' missions. While many regulations originated out of an interest to improve care quality or patient safety, those same regulations, over time, have often become obsolete or redundant. However, in many cases, they remain required despite having outlived their usefulness. The following changes would support hospitals' efforts to adapt to continue offering the highest quality, safest care.

Quality Reporting

52. Repeal the onerous and now outdated 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.
53. 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.
54. Similarly, remove the outdated requirement for hospitals to report staff vaccination rates.
55. 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.

56. Eliminate (or at minimum streamline) the Meaningful Use (now Promoting Interoperability) program as it has outlived its usefulness.
57. Eliminate (or, at a minimum, significantly streamline) the onerous Hospital Consumer Assessment of Healthcare Providers and Systems (patient satisfaction) survey of hospitals, as the quality of the instrument and use of the results have degraded due to low response rates.
58. 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.
59. Remove the requirement for hospitals to report reflecting screening for social determinants of health measures that are not linked to better outcomes.
60. Eliminate the mandatory requirement for Accountable Care Organizations to report quality data electronically, versus allowing reporting via a web interface.
61. Eliminate the Hospital Readmission Reduction Program, as performance has topped out.
62. Suspend the Medicare hospital star ratings program as the methodology is inadequate, including distorted comparisons of hospital performance and a significant time lag.
63. 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.
64. 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, Health Equity Structural Measure and Age-Friendly Hospital measure.
65. 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

66. Minimize in-person hospital surveys for low-risk complaints and resume them virtually.
67. Permanently adopt concurrent validation surveys for CMS accrediting organizations, eliminating duplicative “lookback” surveys that require a full re-survey of hospital compliance with CoPs.
68. 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.

69. 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

70. Repeal the nursing home staffing rule that would not improve quality or safety and would require nearly 80% of all nursing homes — including those with five stars — to increase staffing.
71. 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.
72. Reduce unnecessary burden while ensuring adequate emergency response preparation by reducing the number of required hospital emergency preparedness drills to once a year.
73. 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.
74. 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.
75. Eliminate 42 CFR Part 2 requirements providing special privacy protections for behavioral health patients and protect their privacy under HIPAA.
76. Eliminate the Occupational Safety and Health Administration (OSHA) “walkaround rule” that allows union representatives to accompany OSHA inspectors.
77. 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.
78. Support providers’ access to cheaper drugs by enforcing rules to prevent gaming of patents and other policies that stifle pharmaceutical competition.

TELEHEALTH

As technology and consumer preferences have evolved, more care can safely be delivered via telehealth. However, numerous regulations restrict the use of virtual care.

Addressing the following areas would not only reduce unnecessary burdens on the health care system but also improve clinician capacity, increasing access to care.

79. Remove telehealth originating site restrictions to enable patients to receive telehealth in their homes.
80. 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.
81. Remove restrictions on telehealth modalities to enable a wider range of services (e.g., audio only) to be safely delivered via telehealth.
82. Similarly, remove restrictions on the provider types eligible to perform telehealth.
83. Remove restrictions on the types of distant sites eligible to perform telehealth services.
84. 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).
85. Remove the in-person visit requirements for behavioral health telehealth.
86. Remove restrictions to allow new patients to receive remote physiologic monitoring.
87. 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.
88. Remove in-person visit requirements prior to prescribing controlled substances by establishing a special registration process for virtual prescribers.
89. Remove requirements for hospice recertification to be completed in person to allow for telehealth-based recertification.

WORKFORCE

The health care system’s greatest asset is our workforce. Unfortunately, doctors, nurses, technicians and others are increasingly burned out and leaving the profession, often citing excessive administrative burden that pulls them away from patient care. The following regulatory relief ideas would support our workforce.

90. Eliminate the telehealth physician home address reporting requirement, which compromises workforce safety.
91. Remove requirements for outpatient physical therapy plans of care to be signed off by a physician or nurse practitioner every 90 days.
92. Reform nursing and allied health education payments to relax the CMS interpretation of "director control.”

93. Eliminate or raise the tax-free limit of $5,250 on employer-provided funds spent to train employees in high-demand services like radiology.
94. Repeal the Federal Trade Commission's Non-Compete Clause Rule.
95. Reform rules related to “fair market value” to ensure that hospitals can obtain access to necessary specialist services.
96. Eliminate nurse practitioner practice limitations that are more restrictive under CMS rules than under state licensure.
97. Promote medical licensure reciprocity to allow practitioners to work across state lines.
98. 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.
99. Reduce unnecessary costs in the system by pursuing medical liability reform by eliminating joint and several liability.
100. Similarly, cap non-economic and punitive damages as part of medical liability.