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Advancing Health in America

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Laina Bush
Acting Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Jennifer Burnszynski
Associate Deputy Assistant Secretary, Office of Human Services Policy
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted Electronically

RE: AHRQ 2025-001 Request for Information; Ensuring Lawful Regulation and Unleashing Innovation to Make America Healthy Again

Dear Ms. Bush and Ms. Burnszynski,

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, 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, the American Hospital Association (AHA) appreciates the opportunity to provide comments on the request for information (RFI) to ensure lawful regulation and unleash innovation to promote better health.

The AHA agrees that reducing unnecessary administrative burden can foster improved health for the American people. The rescission of certain regulations will not only support reduced health care costs but also will increase access and quality of care as providers can focus more on direct patient care and less on burdensome paperwork.

This is essential to address, as more than a quarter of all health care spending goes to administrative tasks — totaling more than $1 trillion annually.[1]

As the AHA shared in recent responses to RFIs on deregulation from the Office of Management and Budget, Federal Trade Commission and Department of Justice, there are a variety of actions the administration could take to reduce the burden on hospitals and health systems to improve access, reduce costs and foster competition.[2,3,4] Many of our recommendations included in those responses are relevant to the questions posed in this RFI and can be accessed by the hyperlinks above. In addition, we shared a more comprehensive list of 100 ways to free hospitals from burdensome administrative requirements, an updated version of which is attached. Given our prior responses, we focus these comments on the issue in this RFI that we have not previously addressed directly: regulatory changes to help reverse chronic disease.

We applaud the administration's focus on reducing chronic disease, particularly among children. Compared to other developed countries, the U.S. has higher rates of chronic disease and the lowest life expectancy.[5,6] The rate of premature death in the U.S. is twice that of other developed nations, mainly driven by cardiovascular disease, chronic respiratory illness and chronic kidney disease.[7] The growing prevalence of chronic disease in America has contributed to increased utilization of hospital services and higher case-mix indices, which contribute to higher health care costs.

There are clear areas of alignment between the administration's interest in addressing chronic disease and hospitals' work. Hospitals are a primary source of diagnosis and treatment for individuals with chronic illnesses. Many hospitals also are "moving upstream" and helping to address the root causes of chronic illness before they take hold. Some examples of hospitals' work in this space include:

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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] https://www.aha.org/system/files/media/file/2025/05/aha-response-to-omb-deregulation-rfi-letter-5-12-2025.pdf.
[3] https://www.aha.org/system/files/media/file/2025/05/AHA-Comments-on-FTC-Anticompetitive-Deregulations-RFI.pdf.
[4] https://www.aha.org/system/files/media/file/2025/05/AHA-Comments-on-DOJ-Anticompetitive-Deregulations-RFI.pdf.
[5] https://www.healthsystemtracker.org/chart-collection/how-has-the-burden-of-chronic-diseases-in-the-u-s-and-peer-nations-changed-over-time/#:~:text=Broadly%2C%20a%20larger%20share%20of,of%20depression%20(1.3%20times).
[6] https://www.healthsystemtracker.org/chart-collection/u-s-life-expectancy-compare-countries/#Life%20expectancy%20at%20birth%20by%20sex,%20in%20years,%202023.
[7] https://www.healthsystemtracker.org/chart-collection/what-drives-differences-in-life-expectancy-between-the-u-s-and-comparable-countries/.

- **Prioritizing food and nutrition.** Three out of four hospitals offer nutrition programs to help their community build healthier lives by tackling food and diet-related health challenges. Also, many hospitals have developed "Food Is Medicine" programs, or food prescription programs, to provide fresh fruits and vegetables for patients experiencing food insecurity or to treat chronic conditions.
- **Preventing and managing chronic illnesses.** Most hospitals offer free health screenings, giving patients the opportunity to catch health issues early and prevent the development of complex or long-term conditions when possible.
- **Promoting wellness.** Hospitals provide health education and other tools to help people make healthy lifestyle choices to reduce risk for conditions such as stroke, diabetes, heart disease, certain cancers and depression.

The AHA has compiled a report and list of programs across all 50 states to demonstrate the critical work hospitals do every day to combat chronic illness. There are countless other examples, including hospitals offering transportation programs to help patients get to and from appointments, partnering to build safe housing options, and providing community resources to reduce isolation.

The AHA recently met with several hundred hospital leaders to discuss further efforts to address chronic disease in America. Several key themes emerged:

- Addressing both the causes and the treatment of chronic disease must be done in partnership with community organizations, especially in rural and underserved areas. No single organization has the expertise, resources or capacity to comprehensively address chronic disease alone.
- Chronic disease is not limited to physical ailments. Behavioral and mental health conditions also can be chronic diseases and are frequent co-morbidities alongside physical illness.
- In addition to addressing environmental and systemic issues contributing to chronic disease, patients must also adopt healthy behaviors.
- Hospitals are not reimbursed for interventions that are not directly related to the services they provide. Hospitals and health systems will have limited capacity to take on additional responsibilities without financial support.
- Health care coverage is critical to ensuring access to the care needed to help diagnose, treat and manage chronic diseases.

Recommendations

The AHA offers the following initial recommendations on deregulation opportunities to address chronic disease in the context of this RFI. We look forward to an ongoing dialogue with the administration about how hospitals can support our shared objective of reducing the incidence and burden of chronic disease in this country.

Reduce administrative and coverage barriers to care. Patients often face difficulties accessing health care services due to coverage-related issues. For example, health plans' prior authorization requests reached nearly 50 million in 2023 for Medicare Advantage beneficiaries alone, an increase from 42 million in 2022.[8] Uncertainty about costs — most often a function of understanding health plan cost-sharing obligations — can also create a barrier to care. To help patients access the care they need to prevent, diagnose and manage chronic illness, we encourage the Administration to:

- Fully operationalize the Interoperability and Prior Authorization Final Rule to establish standard electronic prior authorization processes in Medicare Advantage, the Health Insurance Marketplaces and Medicaid. This will help expedite patients' access to medically necessary services.
- Support patients in accessing pricing information by streamlining the various provider and insurer price transparency requirements and eliminating redundancies in reporting. Reducing complexity could help patients better understand their health care costs, potentially reducing a barrier to accessing care.

Advance the sustainable adoption of technology and innovation. Telehealth and other technologies show considerable promise in helping individuals manage their health, including chronic illness. However, as technology and consumer preferences have evolved, many regulations have not kept pace with innovation, potentially impeding patients' access to services that could help them manage their chronic conditions. The AHA encourages the Administration (and Congress where appropriate) to:

- Remove telehealth originating site restrictions within the Medicare program to enable patients to receive telehealth in their homes.
- Remove telehealth geographic site restrictions to enable beneficiaries in non-rural areas to have the same access to virtual care as those in rural areas.
- Remove the in-person visit requirements for behavioral health telehealth.
- Eliminate the telehealth physician home address reporting requirement, which compromises workforce safety.

Facilitate whole-person care. Chronic disease is rarely caused by a single factor, nor is it successfully treated in isolation. There are several ways in which existing regulations stymie providers' ability to provide whole-person care. To address these issues, we encourage the administration to:

- Eliminate 42 CFR Part 2 requirements that protect patient privacy under HIPAA but hinder care team access to important health information, specifically, separation of records pertaining to substance use disorder information. As previously stated, there is a strong link between physical and behavioral health,

[8] https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/.

especially with respect to chronic disease. In order to provide the best care possible, providers must have access to their patients' full medical records.

- Modernize the Stark Law and Anti-Kickback Statute regulations to better protect arrangements that promote value-based care. Whole-person care also entails care coordination and continuity, particularly for patients with chronic disease. Historically, these laws have had the effect of impeding value-based arrangements involving care coordination and/or collaborative electronic platforms by making many of them difficult to undertake without running afoul of either or both laws. Critical steps were taken by the first Trump administration to promote care coordination through value-based safe harbors under those laws, and we continue to support these safe harbors and recommend that they be maintained in their current form. To further address this challenge, we would encourage the adoption of a broad Anti-Kickback Statute safe harbor akin to the "access to care/low risk of harm" exception to the Civil Monetary Penalties Law, which would immunize arrangements that promote access to health care items or services and present a low risk of harm to patients and federal health care programs. This would more effectively protect (and therefore promote) beneficial arrangements that clearly improve patient access to health care items or services.

Sustain the health care workforce. The health care system relies on doctors, nurses and other clinicians to diagnose, treat and manage chronic disease. Unfortunately, our health care workforce is increasingly burning out and leaving the profession, often citing excessive administrative burdens that pull them away from patient care. This can lead to delays in patients accessing the care they need to manage their chronic conditions. In order to support the workforce, the AHA encourages the Administration to:

- Streamline care plan documentation requirements to eliminate duplicate paperwork by removing the requirement for distinct nursing care plans when an interdisciplinary team is caring for the patient and maintains an interdisciplinary care plan.
- Support expanding care capacity by removing Medicare restrictions on nurse practitioners and other advanced practice providers that are often more restrictive than under state licensure.
- Permanently remove the requirements for outpatient physical therapy plans of care to be signed and dated every 90 days.

We look forward to opportunities to work with the administration on these and further recommendations to reduce unnecessary, unfounded or redundant regulations with a particular focus on how we can support individuals to live their healthiest lives. Please contact me if you have questions, or feel free to have a member of your team contact Jennifer Holloman, AHA's director of policy, at jholloman@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

Attachment A: 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.