AAMC Policy and Regulatory Roundup

Issues that impact clinical care provided by hospitals, physicians, and other providers

Policy and Regulatory Updates from the Health Care Affairs Regulatory Team **February 2025**

ANNOUNCEMENTS:

CMS Modifies Award Distribution Methodology for Section 126

The Centers for Medicare & Medicaid Services (CMS) updated the Direct Graduate Medical Education (DGME) website since the publication of the fiscal year (FY) 2025 Inpatient Prospective Payment System (IPPS) Final Rule to reflect a new interpretation of Section 126 of the Consolidated Appropriations Act, 2021, award distribution data. By statute, the CMS is required to award at least 10% of the 1,000 new Medicare-funded positions made available under Section 126 to each of four categories of qualifying hospital: rural hospitals, hospitals over their Medicare full-time equivalent (FTE) cap, hospitals in states with new medical schools or branch campuses, and hospitals that serve geographic Health Professional Shortage Areas (HPSAs, in this context, also referred to as Category 4 hospitals). In the FY 2025 IPPS Final Rule, the CMS announced that after evaluation of the award data from Rounds 1 and 2, the agency would likely not meet the 10% distribution requirement for hospitals that serve Category 4 hospitals. To ensure that Category 4 hospitals met the 10% statutory distribution requirement, the CMS modified the Section 126 distribution program for Rounds 4 and 5 to give first priority to those hospitals, and if slots remained, to use the same HPSA prioritization used in Rounds 1 through 3. After publishing the final rule, the CMS reevaluated the number of FTEs distributed and determined that the 10% requirement for all four categories of qualifying hospital (including Category 4) had been met. Instead, the CMS will use the same HPSA prioritization methodology used in Rounds 1 through 3 for prioritizing distributions in Rounds 4 and 5.

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AAMC Joins Group Letter Requesting Rescission of HIPAA Proposed Security Rule

The AAMC joined several health organizations in a letter urging the Trump administration (PDF) to rescind the proposed rule "HIPAA Security Rule to Strengthen the Cybersecurity of Electronic Protected Health Information" and to engage with organizations to develop a more balanced approach that addresses cybersecurity concerns without imposing excessive burdens on the health care sector. While the letter expressed the group's commitment to enhancing cybersecurity, it raised concerns with the impact the staggering costs and regulatory burden of this regulation would have on hospitals and health care systems, as well as the unreasonable timeline. The letter explained that the complexity and scope of the requirements would necessitate substantial investments in time, resources, and personnel to achieve compliance, diverting funds away from other critical areas, impacting patient care. The group expressed a commitment to working with the administration to find a solution that strengthens cybersecurity and safeguards patient information in the future. Comments on the proposed rule are due March 7 [refer to *Washington Highlights*, Jan. 10.

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AAMC Joins Amicus Brief Urging Supreme Court to Uphold Preventive Care Coverage

The AAMC on Feb. 24 joined the American Hospital Association, the Catholic Health Association, the Federation of American Hospitals, and America's Essential Hospitals to file an amicus brief urging the Supreme Court to reverse the 5th U.S. Circuit Court of Appeals decision in *Braidwood Management v. Becerra*, which invalidates the Affordable Care Act requirement that private health plans cover, without cost-sharing, preventive services recommended by the U.S. Preventive Services Task Force [refer to *Washington Highlights*, May 5, May 19]. Notably, the 5th Circuit ruled that the task force members were principal officers who had not been validly appointed under the Constitution, and therefore the role of the task force in determining mandatory preventive services under the ACA is unconstitutional. Under this ruling, health plans would no longer be required to provide coverage without cost-sharing for preexposure prophylaxis (PrEP) for HIV and other preventive services, such as screenings for breast and lung cancer, certain colonoscopies, maternal depression, and many more. The 5th Circuit limit relief to just the plaintiffs in the case; however, the court's constitutional precedent will be binding in future lawsuits filed within its jurisdiction. The amicus brief states that the "the Task Force's recommendations and the ACA's preventive-care coverage provisions protect the lives and improve the health of men, women, and children," and that "the cumulative societal impact of reimposing cost barriers to these services will be monumental, leading to undiagnosed diseases, shorter lifespans, and higher healthcare spending for everyone." The brief further emphasizes that the task force's preventive care recommendations should be "evidence-based and not subject to undue political pressure." The brief recommends that, if the Supreme Court agrees with the Court of Appeals' Appointments Clause holding, it should sever the "unconstitutional statutory language" so that the "Task Force can continue to make high-quality, evidence-based preventive care recommendations." The Supreme Court is scheduled to hear arguments in the case on April 21.

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Trump Issues Executive Order on Price Transparency for Hospitals and Insurers

In an executive order issued-on Feb. 25, President Donald Trump reaffirmed his commitment to price transparency, signaling a more aggressive approach to making pricing data accessible to patients and enforcing the price transparency rules that were put into effect during his first term. Previously, two major price transparency rules, which became effective in 2021, were issued jointly by the departments of Health and Human Services (HHS), Treasury, and Labor [refer to *Washington Highlights*, Nov. 19, 2019, Oct. 30, 2020]. One rule required hospitals to publish the prices they charged to insurers for a set of 300 common services and a machine-readable file with negotiated rates for every single service the hospital provides, and another rule required insurance companies to publish a more comprehensive list of prices they had negotiated with health care providers. The executive order directs the HHS and the Treasury and Labor departments to ensure hospitals and insurers disclose "actual prices of items and services, not estimates" and take action to ensure "pricing information is standardized and easily comparable across hospitals and health plans" including prescription drug prices. Any new price transparency initiative would require regulatory action or legislation.

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MACPAC Discusses Supplemental Payments, Prior Authorization, OUD

The Medicaid and CHIP Payment and Access Commission (MACPAC) met on Feb. 27 and 28 to discuss a variety of topics including an analysis of targeting of non-disproportionate share hospital (DSH) supplemental and managed care directed payments, access to treatment and medications for opioid use disorder (OUD), and the automation of prior authorization. In the supplemental payment session, commissioners reviewed an analysis of non-DSH supplemental payments focused on upper payment limit (UPL) and graduate medical education (GME) payments. The analysis showed that UPL payments varied based on several factors and often resulted in targeted payments going to government-owned, rural, or teaching hospitals. GME payments targeted teaching hospitals with some states prioritizing targeting primary care and high-need specialties. The commission plans to continue their analysis and construct an updated hospital payment index to assess and compare fee-for-service and managed care payments. The commission built on its analytical work related to access to medications for OUD by discussing stakeholder interviews conducted around federal policies and funding, stigma and misinformation, provider availability, and utilization. The commission plans to include these interviews in a chapter in their June report to Congress. MACPAC also held a panel discussion with state Medicaid officials and an expert on substance use disorders (SUDs) on states' use of Section 1115 waivers to receive federal matching funds for SUD services provided in institutions for mental diseases (IMDs). The panel explored state success and challenges in leveraging 1115 waivers to expand treatment for SUDs in IMDs, which typically are subject to the IMD exclusion prohibiting them from receiving federal matching funds for treating Medicaid beneficiaries. Lastly, commissioners reviewed MACPAC's project on how automation is being used in the Medicaid prior authorization process and the available federal and state levers to regulate the use of automation. The commission plans to conduct a literature review, federal policy review, and stakeholder interviews of seven states as well as develop state profiles. As a next step, MACPAC plans to include a panel discussion on automation in its April meeting.

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AAMC COMMENT LETTERS:

AAMC Submits Comments on CY26 MA Advance Notice

The AAMC submitted comments to the Centers for Medicare & Medicaid Services (CMS) in response to the Calendar Year (CY) 2026 Medicare Advantage (MA) Advance Notice [refer to *Washington Highlights*, Jan. 17]. The AAMC's comments focused on two topics affecting the calculations and methodologies used to determine payment to MA plans (PDF). First, the AAMC urged the CMS to ensure encounter data is accurate and complete prior to incorporating it into a risk adjustment model for MA payment calculations and methodologies. Within the advance notice, the agency had acknowledged it may be capable of phasing in such a model as soon as 2027. Comments asked the CMS to explore options to enforce the reporting of complete, timely, and accurate encounter data and consider the addition of additional data elements to expand what is included in the encounter data collected and made public to improve transparency. Lastly, the AAMC reemphasized its position in response to the CMS' 340B Drug Pricing Program remedy, calling on the agency to address the final rule's failure to remedy the impact these polices had on MA payments [refer to *Washington Highlights*, Aug. 29, 2023]. The CMS stated in the notice that the upcoming reduction in payment for nondrug Outpatient Prospective Payment System (OPPS) in fee-for-service would be reflected in its MA payment methodologies and calculations. However, during the timeframe that OPPS payments were reduced, many MA plans also reduced reimbursement for 340B-acquired drugs, but providers were never repaid from these reductions in MA payments. Comments call on the CMS to work with policymakers and take all possible measures within its authority to ensure hospitals are made whole and not penalized twice with reductions in payments from MA plans due to remedy policies.

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RECORDED WEBINAR:

Feb. 12, 2025: Webinar Covering Section 126 and 4122 Applications

UPCOMING COMMENT DEADLINES:

Mar. 7, 2025: OCR HIPAA Security Rule to Strengthen the Cybersecurity of ePHI

Mar. 18, 2025: DEA Special Registrations for Telemedicine and Limited State Telemedicine Registrations