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 **July 2025**

ANNOUNCEMENTS:

CMS Releases CY26 Hospital Outpatient Prospective Payment System (OPPS) Proposed Rule

On July 17, CMS published the hospital OPPS proposed rule in which it proposes to increase the payment rates by 2.4% for items and services paid under OPPS for CY 2026 and make changes to other policies. The agency proposes to accelerate the reduction in OPPS payment rates for non-drug items and services to offset lump sum payments previously paid to 340B hospitals from 0.5% over 16 years to 2% over six years. Additionally, CMS proposes to expand its site-neutral payment policies to excepted off-campus hospital outpatient departments for drug administration services and seeks feedback on expanding site neutral policies to on-campus clinic visits, as well as establishing a systematic process to identify services at risk of shifting to the hospital setting based on financial incentives and adjusting payments accordingly. Other proposals focus on phasing out the inpatient only (IPO) list, modifying hospital price transparency rules and enforcement, updating MS–DRG relative weights in the inpatient setting using median payer-specific charges as negotiated by hospitals with Medicare Advantage organizations and issuing a notice of intent to survey all hospitals for Medicare OPPS drugs acquisition costs.

Specific to graduate medical education, the agency proposes to modify the definition for approved medical residency programs to include that accreditors may not require as part of accreditation, or otherwise encourage institutions to put in place, diversity, equity, and inclusion programs that encourage unlawful discrimination on the basis of race or other violations of federal law.

CMS also proposes to modify the Outpatient Quality Reporting Program's measure set by adopting one new measure on Emergency Care Access and Timeliness and removing six measures and seeks feedback on new measures of well-being and nutrition. Regarding the Overall Hospital Quality Star Ratings, the agency proposes to modify the methodology to emphasize patient safety by adopting a phased approach to penalizing hospitals in the bottom quartile of performance in the Safety of Care measure group. Comments are due Sept. 15.

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CMS Releases CY26 Medicare Physician Fee Schedule and Quality Payment Program

CMS on July 16 published the calendar year (CY) 2026 Medicare Physician Fee Schedule and Quality Payment Program (QPP) proposed rule that updates payment rates for physicians and other health care professionals, addresses certain telehealth waivers and flexibilities, refines the Shared Savings Program for accountable care organizations, revises requirements under the QPP, creates a new mandatory Ambulatory Specialty Model, and changes other policies.

As required by statute, the CMS proposes to begin implementing two separate conversion factors: one for qualifying alternative payment model (APM) participants (QPs) and one for physicians and practitioners who are not QPs. The proposed CY 2026 conversion factor for QPs is $33.59, representing a 3.83% increase from CY 2025, and for non-QPs the proposed conversation factor is $33.42, representing a 3.62% increase from CY 2025. QP status in CY 2026 is based on meeting APM participation thresholds for the 2024 QPP performance year.

CMS also proposes applying an efficiency adjustment of -2.5% to the work relative value units (RVU) and corresponding intraservice portion of physician time for non-time-based services, as CMS expects these kinds of services to accrue efficiencies over time as "changes in medical practice" occur. This adjustment would generally apply to all codes except time-based codes, such as E/M services, care management services, behavioral health services, and services on the CMS telehealth list. Additionally, citing the rising steady decline in the number of physicians working in private practice, with a corresponding rise in employment by hospitals and health systems, CMS proposes to recognize greater indirect practice expense costs for practitioners in office-based settings compared to facility settings,

CMS also proposes a new mandatory Ambulatory Specialty Model for specialists who treat low back pain or heart failure in an outpatient setting to be announced in a selected core-based statistical area or metropolitan division. The model is proposed to run from 2027 through 2031.

CMS also released a Physician Fee Schedule fact sheet, Medicare Shared Savings Program fact sheet, Ambulatory Specialty Model fact sheet, and a Quality Payment Program fact sheet along with the proposed rule.

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AAMC COMMENT LETTERS:

AAMC Comments on CMS Proposed Rule on Medicaid Provider Tax Waivers

The AAMC submitted July 9 comments (PDF) in response to the CMS Preserving Medicaid Funding for Vulnerable Populations — Closing a Health Care-Related Tax Loophole Proposed Rule. The rule proposes to revise the Medicaid regulations related to the waiver of broad-based and uniform requirements for health care-related taxes that are aimed at ensuring health care-related taxes are generally redistributive. Coinciding with the CMS' proposed rule was the July 4 enactment of the One Big Beautiful Bill Act (OBBBA, P.L. 119-21), which included many significant changes to the Medicaid program, some of which overlap with the proposals contained in this rule. In light of these changes, the AAMC urged the agency to withdraw and reevaluate the proposals included in this rule. The association's comments highlighted the impact limiting these Medicaid financing mechanisms will have on providers and on beneficiaries' access to care. However, should CMS decide to move forward with finalizing the proposals, the AAMC encouraged the agency to limit subjectivity in the waiver approval process and ensure Medicaid financing mechanisms are sufficient to support beneficiaries' access to care. Comments also requested the agency implement a longer transition period of three years for all impacted states to minimize harm to state Medicaid programs.

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AAMC Responds to HHS RFI on Deregulation to Make America Healthy Again

The AAMC submitted a July 14 response to the Department of Health and Human Services' (HHS) request for information on deregulation, as part of the administration's campaign to drive innovation and "make America healthy again." Acknowledging the complex regulatory landscape that academic medical institutions navigate, the AAMC emphasized the need to modernize outdated requirements, harmonize duplicative regulations, and streamline compliance without compromising critical protections.

The letter urged HHS to adopt a balanced, evidence-based approach that incorporates meaningful dialogue with the regulated community and fully adheres to the Administrative Procedure Act's notice and comment requirements. The AAMC's key recommendations included calling for permanent regulatory flexibilities in telehealth and virtual supervision, addressing the delays in care caused by prior authorization, reforms to the QPP and hospital quality reporting, and withdrawal of certain rules with unclear statutory authority or disproportionate burden. The association also encouraged HHS to harmonize conflict of interest rules across agencies, establish a research policy board to improve cross-agency coordination, and align requirements related to single institutional review boards.

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AAMC Comments on Hospital Price Transparency Request for Information

The AAMC responded on July 21 (PDF) to CMS request for information on hospital price transparency, in which CMS solicited feedback on the accuracy and completeness of machine readable files. The AAMC supported the goal to increase health care price transparency for patients; however, expressed concerns with the administration's current approach to price transparency, which is overly burdensome and costly for health systems and hospitals, does not enable patients to understand what they will actually pay for a health care service, and has resulted in widespread confusion for patients. The comments explained that determining accuracy and completeness of machine-readable file data is challenging given the multiple payment policies in health plan/provider contracts that can affect negotiated rates. The AAMC pointed out that the information that the insurer is required to provide to patients under the Transparency in Coverage rules may be much more relevant than any pricing information that providers would be able to deliver to the patient. For a patient, knowledge of their out-of-pocket costs, which depend on plan-specific cost-sharing requirements (such as deductible and co-payment amounts) is the most important information.

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COMMENT DEADLINES:

Due Date: September 12, 2025: CY26 PFS and QPP Proposed Rule
Due Date: September 15, 2025: CY 2026 OPPS Proposed Rule

UPCOMING WEBINARS:

- CY 2026 Proposed Rules for the Quality Payment Program (QPP), Shared Savings Program (SSP), and a New CMMI Ambulatory Specialty Model - August 7
- CY 2026 Medicare Physician Fee Schedule Proposed Rule (PFS) - August 19
- CY 2026 Outpatient Prospective Payment System Proposed Rule - August 21