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 **June 2025**

ANNOUNCEMENTS:

CMS Rescinds EMTALA Guidance on Hospital Obligation to Provide Emergency Abortions
The Centers for Medicare & Medicaid Services (CMS) announced June 3 it is rescinding guidance from July 2022, titled "Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss" (QSO-22-22-Hospitals, PDF) and (QSO-21-22-Hospitals PDF) and the accompanying letter issued under the Biden administration (PDF). The guidance, which was issued after the *Dobbs v. Jackson* decision, clarified that if a hospital emergency department physician believes that an abortion is the stabilizing treatment necessary to resolve a patient's emergency medical condition, the physician must provide that treatment, regardless of state law. The CMS explained that the guidance does not reflect the policy of this administration and reiterated that it "will continue to enforce EMTALA, which protects all individuals who present to the hospital emergency departments seeking examination or treatment, including for identified emergency conditions that place the health of the pregnant woman or her unborn child in serious jeopardy." The Biden administrations' guidance has been central to the litigation on this issue, including a case related to an Idaho abortion law that was heard by the U.S. Supreme Court [refer to *Washington Highlights*, Jan. 24, 2025; March 22, 2024].
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White House Issues Memorandum Targeting Medicaid State Directed Payments
The White House released a June 6 memorandum entitled Eliminating Waste, Fraud, and Abuse in Medicaid. The memo cites states' use of provider taxes to finance the nonfederal share of Medicaid expenditures and to draw down federal Medicaid funds, stating that funds from these taxes are used to pay health care providers "almost three times the Medicare amount." Additionally, the memo asserts that recent growth in Medicaid state directed payments (SDPs) threatens the financial stability of Medicaid and the federal treasury. To address this challenge, the memo directs the secretary of Health and Human Services to eliminate waste, fraud, and abuse in Medicaid, including by ensuring Medicaid payment rates are not higher than Medicare rates. After the publication of the memorandum, **CMS** sent a proposed rule on Medicaid managed care SDPs to the Office of Management and Budget for regulatory review. The House-passed reconciliation bill (One Big Beautiful Bill Act, H.R. 1, PDF) also included a provision that would cap new SDPs at 100% of Medicare rates in expansion states and 110% in non-expansion states.
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MedPAC Releases June 2025 Report to Congress on Medicare Payment Policy
The Medicare Payment Advisory Commission (MedPAC) released its June 2025 Report to Congress, evaluating improvements to Medicare payment systems and issues affecting the Medicare program across seven chapters.
For physicians, MedPAC recommended that for 2026, Congress should replace the existing bifurcated update based on participation in alternative payment models with a single update equal to the Medicare Economic Index minus 1 percentage point. The commission also recommended that Congress instruct the use of timely data that reflects the costs of delivering care to improve the accuracy of Medicare's relative payment rates for clinician services.
The commission also included several chapters analyzing different aspects of Medicare Advantage (MA). Lastly, the commission included a chapter on cost sharing for outpatient services at critical access hospitals (CAHs). Within this chapter, MedPAC recommended that Traditional Medicare beneficiary cost sharing for outpatient services provided at CAHs be based on each hospital's Medicare payment amount instead of on the hospital's charges.
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MACPAC Releases June 2025 Report to Congress on Medicaid and CHIP
The Medicaid and CHIP Payment and Access Commission (MACPAC) issued its June 2025 Report to Congress on June 11, covering a variety of topics organized into five chapters. The first chapter of the report included four recommendations to address the challenges associated with transitioning from pediatric to adult care in Medicaid. The second chapter provides an overview of access to residential behavioral health treatment services for children and discusses access considerations and barriers to appropriate care. The third chapter described findings from the commission's analysis of access to medications for opioid use disorder (MOUD) in Medicaid and outlines barriers to MOUD, which the commission plans to continue in future

sessions. The fourth chapter provides an overview of the Program of All-Inclusive Care for the Elderly, which allows adults ages 55 and older with intensive care needs to remain in the community while receiving integrated care. The report also included a discussion of the self-direction model as a coverage option for Medicaid home- and community-based services.
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Health Plans Announce Voluntary Commitment on Prior Authorization
Health insurance plans accounting for coverage of 260 million individuals pledged a commitment to streamline prior authorization by voluntarily agreeing to new standards. Industry leaders on June 20 agreed to implement a standardized electronic authorization form for all prior authorization requests by 2027. Health plans will also maintain an 80% approval rate of prior authorization requests in real time, meaning that providers would be able to submit a prior authorization request through their electronic health record and receive a decision back within minutes. By 2026, insurers will aim to reduce the number of services subject to prior authorization. Insurers will also commit to honoring a previous health plan's prior authorization during a 90-day transition period when a member changes health plans after starting a course of treatment. The commitment also ensures that prior authorization denials based on medical necessity will be reviewed by a licensed and qualified clinician. CMS Administrator Dr. Oz applauded these commitments and underscored the agency's willingness to pursue regulatory action to streamline prior authorizations.
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CMS Finalizes Rule on ACA Marketplace Enrollment and Eligibility
CMS on June 25 issued the Marketplace Integrity and Affordability final rule (PDF), which applies to issuers offering qualified health plans (QHPs) through federally facilitated Exchanges and state-based Exchanges on the federal platform. Certain provisions of the final rule would go into effect only for the 2026 plan year, sunsetting in plan year 2027. However, many of these policies are also included in the House-passed reconciliation package (H.R. 1), which could codify and extend these changes.
CMS finalized a proposal to end eligibility for QHP and Basic Health Program coverage for individuals with Deferred Action for Childhood Arrivals (DACA). The rule also prohibits individual and small group health plans from offering gender-affirming care as an essential health benefit.
Other proposals finalized by the rule:

- Shorten the open enrollment period by two weeks, to run from Nov. 1 to Dec. 31, instead of the current end date of Jan. 15.
- End the monthly special enrollment period for individuals with incomes below 150% of the federal poverty guidelines.
- Impose pre-verification procedures before an individual can enroll during special enrollment periods.
- Require additional income verification checks for premium tax credits.
- Add limitations on reenrollment, such as by denying enrollment until an enrollee pays past-due premiums and charging a $5 premium for individuals with fully subsidized coverage who are automatically enrolled before confirming their plan.

CMS estimates that between 725,000 and 1.8 million people would lose coverage as a result of the rule.
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Section 5506 – Application for Redistributions of Medicare Supported GME FTE Position from Closed Hospitals
CMS provided public notice that the graduate medical education slots from the closure of Wahiawa General Hospital located in Wahiawa, HI (CCN 120004), and Carney Hospital located in Boston, MA, (CCN 220017) are available for redistribution through Section 5506 of the Affordable Care Act (Pub. L. 111-148). Interested hospitals may access the application through the Medicare Electronic Application Request Information System (MEARIS). The application period for 5506 slot redistributions is 90 days from the publication of the notice of closure, or **July 10, 2025**.
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TABLE V.F.-01: WAHIAWA GENERAL HOSPITAL FTE RESIDENT CAPS

CCN	Provider Name	City and State	CBSA Code	Terminating Date	IME FTE Resident Cap (including+/- MMA Sec. 422 adjustments[1])	Direct GME FTE Resident Cap (including+/- MMA Sec. 422 adjustments)
120004	Wahiawa General Hospital	Wahiawa, HI	46520	April 2, 2024	11.67 + 5.49 sec. 422 increase = 17.16[2]	12.11 + 2.20 sec. 422 increase = 14.31[3]

[1] Section 422 of the MMA, Public Law 108–173, redistributed unused IME and direct GME residency slots effective July 1, 2005.
[2] Wahiawa General Hospital's 1996 IME FTE resident cap is 11.67. Under section 422 of the MMA, the hospital received an increase of 5.49 to its IME FTE resident cap: 11.67 + 5.49 = 17.16.
[3] Wahiawa General Hospital's 1996 direct GME FTE resident cap is 12.11. Under section 422 of the MMA, the hospital received an increase of 2.20 to its direct GME FTE resident cap: 12.11 + 2.20 = 14.31.

TABLE V.F.-02: CARNEY HOSPITAL FTE RESIDENT CAPS

CCN	Provider Name	City and State	CBSA Code	Terminating Date	IME FTE Resident Cap (including+/- MMA Sec. 422[1] and ACA Sec. 5503[2] adjustments)	Direct GME FTE Resident Cap (including+/- MMA Sec. 422 and ACA Sec. 5503 adjustments)
220017	Carney Hospital	Boston, MA	14454	August 31, 2024	73.00 – 9.78 sec. 422 reduction - 0.07 sec. 5503 reduction = 63.15[3]	73.00 – 10.16 sec. 422 reduction - 1.70 sec. 5503 reduction = 61.14[4]

[1] Section 422 of the MMA, Public Law 108–173, redistributed unused IME and direct GME residency slots effective July 1, 2005.
[2] Section 5503 of the Affordable Care Act of 2010, Public Law 111–148 and Public Law 111–152, redistributed unused IME and direct GME residency slots effective July 1, 2011.
[3] Carney Hospital's 1996 IME FTE resident cap is 73.00. Under section 422 of the MMA, the hospital received a reduction of 9.78 to its IME FTE resident cap, and under section 5503 of the Affordable Care Act, the hospital received a reduction of 0.07 to its IME FTE resident cap: 73.00 – 9.78 – 0.07 = 63.15.
[4] Carney Hospital's 1996 direct GME FTE resident cap is 73.00. Under section 422 of the MMA, the hospital received a reduction of 10.16 to its direct GME FTE resident cap, and under section 5503 of the Affordable Care Act, the hospital received a reduction of 1.70 to its direct GME FTE resident cap: 73.00 - 10.16 – 1.70 = 61.14.

COURT DECISIONS:

Supreme Court Upholds Tennessee Law Banning Gender-Affirming Care for Minors

Supreme Court Upholds Tennessee Law Banning Gender-Affirming Care for Minors
The U.S. Supreme Court on June 18 ruled in the case of *U.S. v Skrmetti* (PDF) to uphold a Tennessee law banning gender-affirming care for minors experiencing gender dysphoria. The Tennessee law prohibits medical treatments like puberty blockers or hormone therapy, and surgery for transgender adolescents under the age of 18 experiencing gender dysphoria, while allowing the same medications to treat minors suffering from other conditions. This decision has implications for more than 20 other states that have adopted similar bans. In the 6-3 ruling, the court rejected the challenge brought by three transgender minors, their families, and a physician who had argued the Tennessee law violated the Constitution's guarantee of equal protection under the 14th Amendment. The majority said that the law is not subject to heightened review under the equal protection clause and that Tennessee had "plausible reasons" for restricting access to gender-affirming care (namely concerns about the health risks). In the decision, Chief Justice John Roberts stated that the law does not discriminate on the basis of sex and that courts must give elected officials wide discretion to pass legislation when there is scientific and policy debate about the safety of medical treatments.
The AAMC had joined the American Academy of Pediatrics and more than 20 other national and state medical and mental health organizations in filing an amicus brief (PDF) in September 2024 that focused on ensuring that all adolescents, including those with gender dysphoria, receive the optimal medical and mental health care they need.
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Federal Judge invalidates HIPAA Reproductive Privacy Rule

A federal judge in Texas overturned a Biden administration rule on June 18 prohibiting health care providers from sharing reproductive health care information with law enforcement. The HIPAA Privacy Rule to Support Reproductive Health Care Privacy (PDF) prohibited the use or disclosure of protected health information when it is sought to investigate or impose criminal, civil, or administrative liability on individuals, health care providers, or others who seek, obtain, provide, or facilitate reproductive health care that is lawful under the circumstances in which such health care is provided, or to identify persons for such purpose [refer to *Washington Highlights*, April 26, 2024].
In *Purl v. Department of Health and Human Services* (PDF), the plaintiffs sued HHS alleging that the final rule would harm Texas' investigative abilities into medical care such as abortion, lacks statutory authority, and is arbitrary and capricious. The plaintiffs argued that Congress expressly preserved state investigative authority in the HIPAA statute and, as a result, the HHS may not impose requirements contrary to and not authorized by the HIPAA statute. Specifically, the complaint stated that the final rule unlawfully restricts state officials and law enforcement from obtaining evidence of a crime or other potential violation of state law. "HHS lacks the authority to issue regulations that enact heightened protections for information about politically favored procedures," District Judge Matthew Kacsmaryk stated in his ruling. "The people and their elected representatives remain free to enact their preferred protections for such procedures. And HIPAA and its regulations cannot preempt any state laws that enact 'more stringent' protections."
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AAMC COMMENT LETTERS:

AAMC Comments on FY26 IPPS Proposed Rule

The AAMC submitted June 10 comments (PDF) in response to the CMS Fiscal Year (FY) 2026 Inpatient Prospective Payment System (IPPS) proposed rule. Among the comments provided to the agency, the AAMC asked for an increase to the market basket update to account for increased supply and input costs, citing in particular the expected rise in costs stemming from tariffs. Comments also touched on disproportionate share hospital and uncompensated care payments, the low wage index policy including the transition policy, and additional transparency in the labor-related share. The AAMC thanked the

CMS for providing clarification and public inspection of its longstanding policy for full-time equivalency determinations in cost reporting periods other than twelve months.
Regarding hospital quality programs, the AAMC urged the agency not to introduce unfair measurement and payment bias into the Hospital Readmissions Reduction Program and to ensure that new measures are endorsed by a consensus-based entity as valid and reliable and that they meet the needs of patients, families, and communities to inform their decisions on where to seek high-quality care.
The comments provided details on the proposals for the Transforming Episodic Accountability Model, including asking the CMS to ensure adequate risk adjustment, establish a low-volume threshold with no downside financial risk, implement a consistent, well-tested set of quality metrics for the duration of the model, and refine the primary care referral requirement to improve patient access to care and outcomes.
The AAMC also responded to a request for information on Unleashing Prosperity Through Deregulation of the Medicare Program (PDF), providing specific recommendations on streamlining regulatory requirements, reducing administrative burden of reporting and documentation, and identifying duplicative requirements in the Medicare program.
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AAMC Submits Comments on GME Portions of FY26 IPF PPS Proposed Rule The AAMC provided comments (PDF) June 10 on the graduate medical education (GME) provisions in the fiscal year 2026 Inpatient Psychiatric Facility Prospective Payment System (IPF PPS). Proposals from the Centers for Medicare & Medicaid Services (CMS) focused on additional Medicare-supported full-time equivalent (FTE) positions and increases to certain facility-level adjustments for IPFs. The additional FTEs provided under the proposal would support programs awarded positions through Section 4122 of the Consolidated Appropriations Act, 2023 (P.L. 117-328, PDF) for the time spent in IPF and IPF distinct part unit facilities [refer to *Washington Highlights, Jan. 4, 2023*]. The AAMC's comments also supported a proposed increase to the teaching status and rural location adjustments for the IPF facility level payments.
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AAMC Responds to RFI on Health Technology Ecosystem
The AAMC submitted a June 16 response (PDF) to CMS and the Advanced Standards and Technology Program (ASTP) and Office of the National Coordinator for Health Information Technology (ONC) request for information (RFI) on the digital health ecosystem, which sought feedback on digital health products for Medicare beneficiaries, data interoperability, and broader health technology infrastructure. The AAMC's letter recommended several ways to reduce burden that may be preventing broader adoption of digital health, including extending the telehealth waivers and flexibilities, realigning reimbursement models to recognize clinician effort when leveraging digital health tools, and expanding access to broadband. The letter urged the agencies to prioritize improving the interoperability of electronic health records and empowering patient-driven interoperability to share clinical information while ensuring that providers can control which data from outside sources should be integrated into the medical record. The AAMC's response also reiterated support for improving access and use of evidence-based, clinically relevant technology to improve patient health and well-being.**S**

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COMMENT DEADLINES:
Due Date; July 14, 2025: HHS Ensuring Lawful Regulation and Unleashing Innovation to Make America Health Again RFI
Due Date: July 14, 2025: CMS Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole Proposed Rule
Due Date: July 21, 2025: CMS Hospital Price Transparency Accuracy and Completeness RFI