



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

April 2025

ANNOUNCEMENTS:

CMS Releases FY26 IPPS Proposed Rule

The Centers for Medicare & Medicaid Services (CMS) on April 11 released the [Fiscal Year \(FY\) 2026 Inpatient Prospective Payment System \(IPPS\) proposed rule](#) with comments due June 10. The agency also included a [request for information](#) seeking input on how to streamline Medicare regulations, reduce provider burden, and reduce the cost of private health care expenditures required to comply with federal regulations. CMS is proposing to increase the payment rates by 2.4% for items and services paid under IPPS for FY 2026, reflecting a projected FY 2026 hospital market basket increase of 3.2%, reduced by a 0.8 percentage point productivity adjustment. The agency proposed total uncompensated care-based payments equaling \$7.14 billion (an increase of \$1.5 billion from FY 2025) and empirically justified disproportionate share hospital payments equaling \$3.92 billion in FY 2026. CMS also proposes to discontinue its low-wage index policy in FY 2026 and beyond with a narrow transitional policy in FY 2026 for hospitals significantly impacted by the elimination of the policy, similar to what was implemented in the FY 2025 IPPS interim final rule.

For graduate medical education updates, CMS provided clarification for its policy of calculating full-time equivalent counts for cost reporting periods other than 12 months and provided public notice that slots from the closure of Wahiawa General Hospital located in Wahiawa, Hawaii, and Carney Hospital located in Boston are available for redistribution through [Section 5506](#). In a separate proposed rule, the Inpatient Psychiatric Facility PPS (IPF PPS), the agency proposed an increase to the teaching status adjustment factor and a proposal to allow IPF cap increases associated with the portion of resident training for awarded positions under Section 4122 of the Consolidated Appropriations Act, 2023.

The rule proposed a number of changes to the inpatient quality reporting and performance programs, including the removal of quality measures on health equity and social determinants of health (SDOH) and COVID-19 vaccination, and proposed the inclusion of Medicare Advantage patients to measure hospital performance in certain outcomes measures across programs. The proposed rule retains the mandatory Transforming Episode Accountability Model payment model finalized last year that will bundle payment for certain surgical procedures for a subset of selected hospitals beginning Jan. 1, 2026. CMS proposed to make modifications to quality measurement in the model, changes to the payment methodology and risk adjustment, and removal of the decarbonization and resilience initiative. **STAFF**

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CMS Releases CY26 MA, Part D Policy and Technical Changes Final Rule

CMS on April 5 released the [Contract Year 2026 Medicare Advantage \(MA\) and Medicare Part D Policy and Technical Changes Final Rule](#). The agency finalized several proposals, including those to implement vaccine and insulin cost-sharing changes included in the Inflation Reduction Act, improve enrollee protections in inpatient settings by clarifying requirements for MA coverage determinations, and further integrate Dual Special Needs Plans (D-SNPs) by requiring integrated health risk assessments (HRAs) and member ID cards for both Medicare and Medicaid. Notably, CMS opted not to finalize several proposals. The agency specifically stated they will not finalize proposals to revise the annual health equity analysis of utilization management policies, implement guardrails for artificial intelligence (AI), or provide coverage of GLP-1 medications for obesity in Medicare Part D plans and Medicaid. However, CMS does intend to explore future rulemaking related to AI. The agency did not indicate whether they would finalize several additional proposals related to network adequacy, provider directories, cost sharing for behavioral health, marketing, and Medical Loss Ratio reporting. Lastly, in accordance with the [Jan. 31 Unleashing Prosperity Through Deregulation executive order](#), the agency outlined policies under consideration for deregulation, which include the health equity index reward for Star ratings, the annual health equity analysis of utilization management policies, requirements for MA plans to provide culturally and linguistically appropriate services, and quality improvement and HRAs focused on equity and SDOH.

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CMS Releases CY26 MA, Part D Rate Notice

CMS on April 7 released the [Contract Year 2026 Medicare Advantage \(MA\) and Medicare Part D Rate Notice \(PDF\)](#). The rate notice, issued annually, provides updates to MA payment rates and technical updates to keep MA payments up to date and accurate. Originally, in the 2026 Advance Notice, CMS had proposed an effective growth rate of 5.93%, resulting in an expected average change of 4.33% or 2.23% without accounting for the MA risk score trend. However, due to additional fee-for-service (FFS) data from the fourth quarter of 2024 not available at the time of the Advance Notice, the agency is finalizing a new effective growth rate of 9.04% for an expected increase in revenue of 5.06% without the risk score trend for CY 2026. This is significantly higher than what MA plans have received in recent years and is expected to result in \$25 billion more in payments to plans in 2026. The agency will also complete the phase-in of two technical changes, including the completion of the three-year phase-in of the 2024 CMS-Hierarchical Condition Category updated risk adjustment model. This finalizes the shift in MA's diagnosing coding from ICD-9 to ICD-10 and removes certain codes from the hierarchical condition categories model. Additionally, the agency is finishing the final phase of its implementation of a technical adjustment to the per capita cost calculations used for determining the effective growth rate. This adjustment is specifically related to how indirect medical education and direct graduate medical education costs are included in that calculation.

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MedPAC Reviews Payment for Physicians, Topics in MA

The Medicare Payment Advisory Commission ([MedPAC](#)) met on April 10 and 11 to vote on recommendations to update and improve the accuracy of physician fee schedule (PFS) payments and a number of issues related to Medicare Advantage (MA). Commissioners voiced concerns about whether current law updates to payments under Medicare's PFS will continue to be adequate to ensure beneficiary access to physician care given inflation trends. They have also previously discussed concerns about the accuracy of relative value units under the PFS, including the potential for duplicative payments for practice expense when physician services are provided in hospital outpatient departments or other facility settings. At April's meeting, the commission voted to adopt the following two draft recommendations: (1) Congress should replace the current-law updates to the PFS with an annual update based on a portion of the growth in the Medicare Economic Index (MEI; such as MEI minus 1 percentage point); and (2) Congress should direct HHS to improve the accuracy of Medicare's relative payment rates for clinician services by collecting and using timely data that reflects the costs of delivering care.

Commissioners also discussed several issues related to MA plans including concerning trends in the Part D plan market and the impact on market stability for these plans. Additionally, commissioners reviewed an analysis of the utilization of supplemental benefits in MA plans and found that \$38 billion in MA rebates were used to provide non-Medicare services in 2024. Data on supplemental benefits is currently limited, with only vision and hearing services potentially including sufficient encounter data for analysis, but additional data may soon be available for analysis due to stronger requirements beginning in 2024. The commission plans to include a chapter on these topics in its June report to Congress.

Commissioners reviewed and discussed analytic findings on the impact of MA on rural hospitals' profitability. MedPAC staff found that MA has grown rapidly in rural areas and that MA growth is associated with reduced rural hospital inpatient and post-acute volume since MA beneficiaries are more likely to bypass rural hospitals than fee-for-service beneficiaries. However, the MA growth has not significantly impacted revenue, costs, or profits for the rural hospitals.

Moving forward, MedPAC plans to refine its analysis to determine if the findings continue.

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MACPAC Discusses Statistics and Trends, Financing, and Recommendations to Congress

The Medicaid and CHIP Payment and Access Commission (MACPAC) met on April 10 and 11 to discuss a variety of topics including sessions contextualizing Medicaid statistics, trends, payment, and financing. Additionally, commissioners voted to advance several recommendations related to Children and Youth with Special Health Care Needs (CYSHCN) Transitions of Care. These recommendations will appear in the Commission's June report to Congress.

The Commission began the meeting by reviewing two sessions referred to as "Medicaid in Context," which build on the Commission's [annual MACStats](#) report. The first session reviewed key statistics and trends related to demographics of enrollees, enrollment, spending trends, and coverage of services by Medicaid including maternal health, long-term care, and behavioral health services. The second session reviewed financing mechanisms for the federal and non-federal share, Medicaid payments to providers including FFS supplemental and managed care directed payments, and the impact of Medicaid payments on providers.

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President Trump Issues Executive Order on Lowering Prescription Drug Prices

President Donald Trump, in an [April 15 executive order](#), directed federal agencies to implement policies to lower drug prices, improve pharmacy benefit manager transparency, and build on provisions of the Inflation Reduction Act (IRA, [P.L. 117-169, PDF](#)). The order instructs the secretary of the Department of Health and Human Services (HHS) to, within 180 days, publish a plan to conduct a survey of actual acquisition costs for covered outpatient drugs administered at Outpatient Prospective Payment System (OPPS) hospitals. It also directs the HHS secretary to consider adjusting Medicare drug payments to OPPS hospitals to more closely resemble acquisition costs reported on the survey.

In another provision, the secretary is tasked with proposing a regulation to ensure that Medicare is not encouraging a shift in drug administration volume from physician office settings to more costly hospital outpatient departments, referencing site-neutral policies that reduce payment for certain OPPS services by 60%. Additionally, the executive order calls for the development of a payment model to allow Medicare to obtain better value for high-cost prescription drugs and biologicals, which could be a reference to the Most Favored Nation model that was ultimately withdrawn during Trump's first term. Other sections of the executive order include requiring community health centers to pass on the 340B price of insulin and injectable epinephrine to their low-income patients; encouraging importation of prescription drugs to lower drug prices; improving on the provisions of the IRA by identifying improvements on stabilizing and reducing Medicare Part D premiums, issuing guidance to prioritize the selection of high-cost prescription drugs, and aligning the treatment of small molecule drugs with that of biologicals under the IRA; and improving payments for drugs under the Medicaid Drug Rebate Program by ensuring accurate rebates and linking payments to value. The White House [published an accompanying fact sheet](#) summarizing provisions of the executive order.

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AAMC Joins Amicus Brief Urging Court to Preserve Medicaid Funding Sources

The AAMC on April 21 joined America's Essential Hospitals, the Children's Hospital Association, and the North Carolina Healthcare Association to [file an amicus brief \(PDF\)](#) in the U.S. Court of Appeals for the 4th Circuit urging the court to preserve states' ability to fund their nonfederal share of their Medicaid programs through public funds transferred by local governments, known as intergovernmental transfers (IGTs). The lawsuit, filed by South Carolina, challenges CMS' disapproval of a state plan amendment because the supplemental Medicaid payments to teaching hospitals it sought to establish would have been financed using IGTs derived from patient care revenues, rather than taxes or appropriations. The amicus brief argues that federal law does not require IGTs to be derived only from state and local taxes or appropriations, and therefore the CMS administrator's decision conflicts with federal law and regulations and contradicts the agency's decades-long approach and policies.

Notably, the administrator's decision would deprive providers of a significant amount of Medicaid funding used to care for Medicaid patients. The brief explained, "Amici's members use Medicaid payments to fund high-cost, negative-margin services (e.g. trauma care, advanced neonatal intensive care, burn care, transplants); expand access to behavioral health care substance use disorder services; improve maternal health outcomes; address chronic conditions, such as cancer, heart disease, diabetes and obesity; expand residency training programs, fuel biomedical research to develop lifesaving medical innovations; and increase access in rural areas. If the Administrator's decision is upheld, Amici's members will be forced to curtail services that are critical to keeping Americans healthy."

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Supreme Court Upholds HHS Interpretation of Medicare DSH Calculation

In a [7-2 decision \(PDF\)](#), the Supreme Court on April 29 upheld the HHS' calculation of Medicare disproportionate share hospital (DSH) payments, affirming the decision of the U.S. Court of Appeals for the District of Columbia Circuit. In *Advocate Christ Medical Center v. Becerra*, over 200 hospital plaintiffs challenged the HHS' interpretation of when an individual is entitled to supplemental security income (SSI) benefits in determining which low-income patient days are included in the Medicare fraction of the DSH calculation. In calculating DSH payments from 2006 to 2009, HHS maintained that an individual is entitled to SSI benefits (and thus included in the numerator of the Medicare fraction) only if that individual receives SSI cash benefits during the month of their hospitalization. The plaintiff hospitals disagreed with this interpretation, arguing that the agency should include patients who are deemed eligible for SSI benefits, even if they do not receive cash benefits in a given month. The AAMC, the American Hospital Association, and other hospital associations supported the plaintiffs' position in an [amicus brief \(PDF\)](#), noting the harm HHS' interpretation has on hospitals' DSH payments.

The majority sided with HHS, concluding that "an individual is 'entitled to [SSI] benefits' ... when she is eligible to receive an SSI cash payment" and dismissed plaintiffs' arguments that the receipt of noncash benefits should be included in determining SSI eligibility and that SSI eligibility continues for a 12-month period. In her dissenting opinion, Justice Ketanji Brown Jackson disagreed with the majority's interpretation of SSI eligibility and cited the 2024 amicus brief, stressing that undercounting low-income patients in the DSH formula could "cause many such hospitals to close their doors entirely, such that patients from our Nation's poorest communities may not be served at all."

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COMMENTS:**AAMC Comments on CMS Marketplace Integrity and Affordability Proposed Rule**

The AAMC [submitted comments \(PDF\)](#) on April 9 in response to the CMS Marketplace Integrity and Affordability proposed rule. The CMS' proposals aim to revise standards for issuers offering qualified health plans (QHPs) through federally facilitated Exchanges and state-based Exchanges on the federal platform as established by the Patient Protection and Affordable Care Act. The association's comments highlighted the potential negative downstream effects from proposals that limit access to the Marketplace and urged CMS to explore options to maintain the integrity of the Marketplace without jeopardizing enrollee coverage and access. Specifically, the AAMC asked CMS not to impose additional barriers to coverage but rather incentivize healthy individuals to select and maintain coverage to prevent adverse selection. Comments also urged the agency to ensure that enrollees are notified of any changes in the updated plan cost information or financial assistance for the upcoming plan year prior to closing the open enrollment period. Additionally, the AAMC urged CMS not to finalize its proposal to alter its interpretation of "lawfully present" for the purposes of determining eligibility in a QHP or insurance affordability programs to exclude those with Deferred Action for Childhood Arrivals status.

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WEBINAR RECORDINGS:

April 23, 2025: [Transforming Episode Accountability Model \(TEAM\) established in the FY2025 Inpatient Prospective Payment System](#) Passcode: mu@k1bhj

UPCOMING WEBINAR RECORDINGS:

May 12, 2025 at 12:30pm EST: [Fiscal Year \(FY\) 2026 Inpatient Prospective Payment System Proposed Rule](#)

May 15, 2025 03:00pm EST: [The VA's New Onboarding Policy Preparation and Emerging Best Practices](#)

The Group on Resident Affairs is hosting a webinar highlighting recent VA policies regarding the onboarding and credentialing of Health Professions Trainees (HPTs) on clinical rotations at VA facilities. As a companion to a September 23, 2024, presentation, a panel of GME leaders will provide updates on the roll out of the new requirements and offer observations on best practices for academic affiliates to avoid unnecessary delays in resident and student onboarding.

UPCOMING COMMENT DEADLINES:

Due Date: May 12, 2025: OMB Deregulation Request for Information

Due Date: May 27, 2025: DOJ Public Input Opportunity: Unnecessary Laws and Regulations that Raise Barriers to Competition

Due Date: June 10, 2025: FY26 Inpatient Prospective Payment System (IPPS) and Medicare Deregulation Request for Information