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 **September 2025**

ANNOUNCEMENTS:

CMS Issues Guidance Implementing State Directed Payments Provision of OBBBA

The Centers for Medicare & Medicaid Services (CMS) on Sept. 9 issued guidance implementing Section 71116 (PDF) of the One Big Beautiful Bill Act (OBBBA, P.L. 119-21, PDF) related to Medicaid state directed payments (SDPs). Section 71116 reduces the total payment rate for non-grandfathered SDPs to 100% of the Medicare rate for SDPs in expansion states and 110% in non-expansion states for rating periods beginning on or after the July 4 date of enactment of the OBBBA. Grandfathered SDPs can continue to be paid at their current rate, but states must begin to reduce the payment rate for grandfathered SDPs by 10 percentage points each year beginning in 2028.

Under 71116, certain SDPs can be grandfathered if they were approved or a preprint was submitted before a date prescribed in legislation. The guidance describes the CMS' initial interpretation of the grandfathering provision of Section 71116, defining terms such as applicable rating period and "completed preprint." While grandfathered SDPs can continue to be paid at the total payment rate that was approved in the preprint, the CMS emphasizes that states cannot increase the total dollar amount of a grandfathered SDP but are free to decrease the amount at any time before Jan. 1, 2028.

CMS states that SDPs with an application approved before the Sept. 9 date of the letter will be preliminarily grandfathered. The agency says that for other preprints under review, it will include preliminary feedback in its adjudication letters on whether that preprint is likely eligible for the grandfathering period.

The guidance indicates that the CMS is exploring other limits to SDPs beyond those enacted by the OBBBA. The CMS noted that the agency plans to issue a proposed rule to further address the topic of SDPs.

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MedPAC Reviews Medicare Payment Oversight, MA's Impact on Hospital Finances

The Medicare Payment Advisory Commission (MedPAC) met on Sept. 4 and 5 to discuss Medicare payment accuracy, oversight to ensure sustainability, context for Medicare payment, and the impact of Medicare Advantage (MA) enrollment on hospital finances. Commission staff presented updated analysis of Medicare payment and funding to provide fresh context regarding Medicare spending. The analysis included an observable decline in spending in Medicare Part A services, funded through payroll taxes, and increased spending on Part B, funded through general government revenues and premiums, which is likely to make health care less affordable for Medicare patients. Commissioners focused their discussion on a new analysis regarding health care consolidation and workforce concerns, notably health care workers who are not directly reimbursed under Medicare fee schedules and payment systems.

Lastly, MedPAC staff presented on the association between MA enrollment and hospital financing as a greater share of Medicare eligible beneficiaries enrolled in MA plans. On average, the commission found increases in MA enrollment are not associated with statistically significant changes with hospital profit margins but were associated with lower hospital revenue and costs. However, this varied by ownership status depending on whether hospitals and plans were financially integrated or not. Financially integrated hospitals did not show large revenue changes when MA grew, but non-financially integrated hospitals did experience revenue and cost declines. The commission also discussed the positive correlation between MA enrollment and the amount of uncompensated care-based payments per discharge, in both fee-for-service and MA.

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MACPAC Discusses Recent Legislative Changes to Medicaid, Medicaid Work Requirements

The Medicaid and CHIP Payment and Access Commission (MACPAC) met on Sept. 18 and 19 to discuss topics including upcoming changes to Medicaid following the enactment of the One Big Beautiful Bill Act (OBBBA) (P.L. 119-21) with multiple sessions on Medicaid work requirements. Commissioners also reviewed and discussed background on behavioral health in Medicaid and the State Children's Health Insurance Program (CHIP) as well as the Medicare-Medicaid plan transition to integrated Medicare Advantage (MA) dual eligible special needs plans. The commission plans to continue monitoring the Medicare-Medicaid plan transition and share preliminary findings from their Transformed Medicaid Statistical Information System claims data analysis related to behavioral health utilization in future meetings.

Commissioners began their Thursday sessions with an overview of the Medicaid and the State CHIP provisions enacted with the passage of OBBBA, including those related to eligibility and enrollment, financing, services and payment, and the Rural Health Transformation Program. Following this, commissioners conducted a deeper dive into the newly enacted Medicaid work requirements, followed by a discussion panel of state-level experts on their experience with implementing these new requirements. Panelists discussed how they intend to operationalize work requirements mandated by the OBBBA, such as implementing necessary information technology systems, and discussed areas where additional federal guidance is necessary.

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CMS Releases Notice of Funding Opportunity, Application for RHTP

The Centers for Medicare & Medicaid Services (CMS) on Sept. 15 issued a Notice of Funding Opportunity for states to apply to receive funding from the Rural Health Transformation Program (RHTP). The RHTP provides $50 billion in program funding that will be allocated to approved states over five years, with $10 billion available each year beginning in fiscal year 2026. Half of the funding will be evenly distributed to all states with an approved application.

The other half will be awarded to approved states based on individual state metrics and applications that reflect the greatest potential for and scale of impact on the health of rural communities. The CMS seeks to utilize the RHTP to further five strategic goals included in the funding opportunity: make rural America healthy again, sustainable access, workforce development, innovative care, and technology innovation.

Only the 50 states are eligible to apply, but AAMC-member institutions may engage with state partners to support the development of the state's application for funding. The CMS will only accept one application per state. Territories, the District of Columbia, local governments, hospitals, universities, nonprofits, federally recognized Tribes, or individuals are not eligible to apply. Applications are open to all 50 states until Nov. 5. The CMS will announce awardees by Dec. 31, in time for the first year of funding. There is only one opportunity to apply for funding and one application period for all five years of this program.

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Presidential Proclamation Seeks to Limit H-1B Visas

President Trump issued a proclamation meant to limit the number of H-1B visas by increasing the application fee to $100,000. The proclamation took effect Sept. 21 and will apply to new application filings only (PDF). The justification given for the proclamation was the "systemic abuse of the program" in certain sectors of the workforce, specifically highlighting the impact in science, technology, engineering, and math fields. In 2024 there were roughly 10,200 physicians in the United States practicing with H-1B visa status. Part of the proclamation allows the secretary of the Department of Homeland Security (DHS) to exempt some international workers if their hiring is considered "in the national interest and does not pose a threat to the security or welfare of the United States."

The AAMC joined 53 national medical groups and organizations in a letter to DHS requesting physicians be exempt from the higher H1-B filing fees per the National Interest Waiver language included in the proclamation [refer to related story].

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

The Centers for Medicare & Medicaid Services (CMS) on Sept. 18 released a second Contract Year (CY) 2026 Medicare Advantage (MA) and Medicare Part D Policy and Technical Changes Final Rule. The agency issued their first final rule for CY 2026 in April, but had left many proposals unaddressed [refer to *Washington Highlights*, April 11].

The final rule will require Medicare Advantage Organizations (MAOs) to submit MA provider directory data to the CMS for publication and inclusion online in Provider Directories within the Medicare Plan Finder. The agency is not finalizing their proposal to require plans attest data is consistent with MA network adequacy data requirements, but it is finalizing a requirement for MAOs to attest at least annually the information provided is accurate. While the data will still be due to the agency by Jan. 1, 2026, the CMS may not make the data publicly available until a later date, following a testing period and additional guidance on the required data. Within the final rule, the agency clarified that the responsibility of submitting data would be on the plans and it would be up to them to work with providers on updating data as necessary.

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VA Issues RFP for New Resident Positions Through PPGMER

The Department of Veterans Affairs (VA) on Sept. 18 issued a request for proposals (RFP) for the second round of resident position distributions through the Pilot Program on Graduate Medical Education and Residency (PPGMER). Authorized under Sec. 403 of the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 (PL 115-182), the PPGMER authorizes no fewer than 100 resident positions at VA-covered facilities, which are primarily Indian Health Service and Federally Qualified Health Center locations. The VA awarded 61 resident positions at 10 sites in four states through the first RFP. More information about the application process and eligibility can be found on the VA's Office of Academic Affiliations website.

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AAMC COMMENT LETTERS:

AAMC Comments on HRSA 340B Rebate Model Pilot Program

The AAMC submitted comments to the Health Resources and Services Administration (HRSA) in response to the agency's 340B Rebate Model Pilot Program. HRSA's 340B Rebate Model Pilot Program allows for a minimum one-year test of rebate models limited only to drug manufacturers with Medicare Drug Price Negotiation Program Agreements for drugs on the Medicare Drug Price Negotiation Selected Drug List for 2026.

The AAMC opposed the use of rebate models in the 340B program (PDF) and urged HRSA not to move forward with the use of these models. Comments highlighted the negative impacts rebate models would have on the 340B Program and AAMC members. The association's greatest concerns with the pilot program include the insufficient implementation timeline, the absence of information on how HRSA will enforce 340B compliance under a rebate model, the lack of a clear process for disputing improperly rejected rebate requests, and the substantial administrative burden it would impose on 340B hospitals. Members of Congress echoed these concerns in a Sept. 9 bipartisan letter to Health and Human Services (HHS) Secretary Kennedy urging the administration to withdraw its plans for a rebate model. Drug manufacturers have until Sept. 15 to apply for the pilot program. HRSA will issue approvals by Oct. 15 for implementation by Jan. 1, 2026.

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AAMC Comments on CY26 Physician Fee Schedule and Quality Payment Program Proposals

The AAMC submitted comments (PDF) to CMS on Sept. 11 in response to the calendar year (CY) 2026 Physician Fee Schedule and Quality Payment Program (QPP) proposed rule. CMS proposed two 2026 conversion factors: one for qualified participants (QPs) in alternative payment models at $33.59 and the other for non-QPs at $33.42, as required under law. The proposed conversion factors represent increases of 3.83% and 3.62%, respectively from 2025. A significant portion of the increase is due to the one-time 2.5% increase provided by Congress in the One Big Beautiful Bill Act. Given the critical importance of patient access to health care services and the ongoing challenges faced by physicians, the AAMC encouraged CMS to support stakeholders' efforts urging Congress to pass legislation that would provide an

In response to the proposed efficiency adjustment, a -2.5% cut to physician work valuation for all time-based services, and proposed change to practice expense to shift valuation of professional services provided in facilities to services provided in physician offices, the AAMC urged CMS not to arbitrarily modify valuations of physician services based on one-size-fits-all adjustments. Instead, the association's comments recommend the agency work with stakeholders on alternative policy options to achieve its goals to appropriately pay for services while improving patients' access to care.

The AAMC also asked CMS to extend the pandemic-era telehealth flexibilities where the agency has the authority to do so, for example, to allow virtual supervision of residents for telehealth services in all training locations, and further encouraged CMS to work with Congress to make permanent, or at a minimum, to provide a two-year extension, of the remaining telehealth flexibilities.

In response to the newly proposed Ambulatory Specialty Model, the AAMC recommended that CMS improve model design to ensure models support specialty engagement in value-based care delivery, including by making participation voluntary, allowing group practice participation and reporting, and better aligning model components to scoring and financial risk under the Merit-based Incentive Payment System.

Specific to the QPP, the AAMC's comments recommended that CMS work with stakeholders to identify longer term policy solutions that would bolster quality of care, improve access for all beneficiaries, improve patient outcomes, and reduce burden.

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AAMC Comments on CY26 OPPS Proposed Rule

The AAMC submitted comments in response to CMS' Calendar Year (CY) 2026 Outpatient Prospective Payment System (OPPS) proposed rule.

The AAMC's comments focused on the financial impact and negative consequences of many of CMS' proposals (PDF) and asked for an increase to the proposed 2.4% payment update to reflect higher growth in labor and supply costs amid financial uncertainty. The AAMC urged the agency to not accelerate the existing 16-year claw back timeline of nondrug items and services as part of its remedy for Part B drug payment reductions to 340B hospitals. The association also opposed CMS' proposal to extend "site-neutral" policies to drug administration services in excepted off-campus provider-based departments, as these payment cuts are likely to reduce access to care, particularly for the sickest and most complex patients.

Comments further expressed significant concerns with the expansion of "site-neutral" payment policies to on-campus clinic visits or for other services provided at on- or off-campus Hospital Outpatient Departments as these significant cuts in payment would reduce access to care. The AAMC also urged CMS to withdraw its survey of OPPS drug acquisition costs due to the significant burden associated with collecting data that quickly becomes outdated from frequent acquisition cost changes and should not base Part B drug reimbursement rates on the results of any future survey. Lastly, the AAMC requested that the agency not eliminate the inpatient only list and instead encouraged CMS to continue to solicit stakeholder feedback to comprehensively evaluate on an annual basis which procedures should remain in the inpatient setting, balancing concerns about beneficiary safety and outcomes and evolving standards of care.

Specific to graduate medical education, the AAMC asked the agency not to finalize the proposed changes to the definition of approved medical residency program. Related to quality in the Outpatient Quality Reporting Program, the comments encouraged CMS to adopt proposed measures with modifications, finalize measure modifications and removals as proposed, and align Extraordinary Circumstances Exception policies with those policies adopted for CMS inpatient hospital quality reporting and performance programs.

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AAMC Comments on DHS's Proposed Repeal of Duration of Status for F, J, and I Visa Holders

On Sept. 29, the AAMC submitted a comment letter strongly opposing the Department of Homeland Security's (DHS) **proposed rule** to eliminate duration of status (D/S) for most F, J, and I visa holders. Under the longstanding D/S policy, these visa holders, primarily international students including PhD researchers, resident physicians, and postdoctoral scholars, are permitted to remain in the United States for the full length of their academic or training program. The DHS proposal would replace this system with a fixed-term visa, capped at four years, tied to the length of the individual's program. Visa holders needing additional time would be required to file for an Extension of Status (EOS) through U.S. Citizenship and Immigration Services, creating new layers of cost,

delay, and uncertainty. In its letter, the AAMC emphasized the significant drawbacks of this proposed shift, particularly the administrative and financial burdens it would impose on international learners, the institutions that train them, and the American taxpayer. The strength of the current D/S policy is the flexibility it provides, which allows medical trainees and research scholars to complete their programs without interruption, while maintaining exceptionally low rates of misuse.

RECORDED WEBINARS:

- Fiscal Year (FY) 2026 Inpatient Prospective Payment System Final Rule - September 10