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Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1516-ANPRM
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Ensuring Safety Through Domestic Security with Made in America Personal Protective Equipment (PPE) and Essential Medicine Procurement by Medicare Participating Hospitals

Dear Administrator Oz,

The AAMC[1] welcomes this opportunity to comment on the proposed rule entitled "Medicare Program; Ensuring Safety Through Domestic Security with Made in America Personal Protective Equipment (PPE) and Essential Medicine Procurement by Medicare Participating Hospitals," 91 FR 3851 (January 29, 2026), issued by the Centers for Medicare & Medicaid Services (CMS or the agency).

In the Advance Notice of Proposed Rulemaking (ANPRM), CMS requests public comments on potential policy options, including a publicly reported designation given to hospitals that demonstrate a commitment to purchasing domestically produced PPE and essential medicines and a payment adjustment that would recognize the additional costs these hospitals incur when purchasing such products. These policy options are informed by CMS' goal to "foster a more resilient supply chain for American-made [PPE] and essential medicines to secure our nation's health and safety and to reflect the additional resource costs incurred when procuring these domestically manufactured items" (p. 3851). **Under the right circumstances, the AAMC supports CMS' goal to increase the purchase of PPE and essential medicines from domestic**

[1] The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, clinical care, biomedical research, and community collaborations. Its members are all 163 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 Canadian medical schools accredited by the Committee on Accreditation of Canadian Medical Schools; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Through the Alliance of Academic Health Centers International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe.

sources. However, there are many factors and considerations CMS must weigh when making policy decisions to support the procurement of domestically manufactured supplies and essential medicines as outlined in the comments below.

The AAMC and its members have a strong interest in ensuring supply chain resiliency by diversifying production and reducing dependence on any one source of medical supplies and medicines. Academic health systems and teaching hospitals play a unique and critical role in the nation's health care infrastructure. As regional referral centers, trauma centers, and hubs for specialized care, these health systems treat some of the most medically complex patients while also training the next generation of physicians and conducting cutting-edge biomedical research. AAMC academic health systems and teaching hospitals also serve a critical emergency response function, investing consistently to maintain a heightened level of preparedness to engage rapidly in response to any event at any time. They have years of experience in mobilizing resources during times of crisis and often lead regional responses in collaboration with their state and local departments of health, regional emergency management systems, and all other major players in emergency response. At the same time, policies aimed at incentivizing domestic production must account for the operational realities of modern hospital supply chains—including system-level procurement processes, long-term contracting arrangements, and clinical product standardization across complex care environments—to ensure implementation does not disrupt patient care or create unintended patient safety risks.

Furthermore, drug and supply shortages continue to pose challenges for both providers and their patients, underscoring the need for a diversified and reliable supply chain. Based on the American Society of Health-System Pharmacists (ASHP) and University of Utah drug shortages database, the United States reported over 300 active drug shortages in 2023.[2] These shortages dramatically impact patient care, and although drug shortages are an enduring problem, they have increased acutely in recent years. Between March 2018 and March 2023, active drug shortages rose by almost 50 percent. The AAMC appreciates the agency identifying ways to increase the purchase of domestically produced PPE and essential medicines in a way that would also reduce burden on hospitals while ensuring patient safety and access. We provide additional comments on the topics in the ANPRM below.

CMS Should Work with Public and Private Stakeholders to Ensure a Robust Domestic Supply Chain

CMS should adopt a holistic, multi-sector approach to ensuring a robust domestic supply chain. Encouraging hospitals to purchase domestic supplies is only one piece of a more concerted strategy. There are multiple external factors affecting domestic supply, such as current domestic manufacturing capacity, demand spikes, product shortages, public health emergencies (PHEs), and natural disasters. The COVID-19 pandemic showed the fragility and weaknesses of the global supply chain. The goal of the designation and payment adjustments is to sustain a level of supply resilience for PPE and essential medicines that is critical during a PHE. We agree that

[2] Fox, Erin, "Drug Shortage Statistics," American Society of Health-System Pharmacists", March 31, 2023.

more needs to be done to ensure a stable health care supply chain, and while the payment adjustments alone are not enough to build up the domestic supply chain, the steps CMS outlines in the notice would increase demand for domestically produced PPE and essential medicine, thereby stimulating domestic production. Steps that could strengthen the supply chain are highlighted in the paragraph that follows.

We continue to stress the need to strengthen current supply chains, specifically the need for more than one supply chain to ensure adequate product supply. CMS should work with other agencies that play a critical role in developing and maintaining the domestic supply chain, including the Administration for Strategic Preparedness and Response (ASPR) and the Department of Defense, as well as with private sector stakeholders, to develop a cohesive national strategy for addressing the impact future PHEs may have on the nation's health care supply chain. ASPR, for example, serves a critical role in ensuring the resiliency of the supply chain and improving supply chain surge capabilities through its Industrial Base Expansion (IBx) initiative.[3] Through the IBx, ASPR seeks to bring together private and public stakeholders and enter into contracts with domestic manufacturers to increase the production of domestically produced PPE, testing and diagnostic supplies, and key ingredients in the productions of pharmaceuticals, such as active pharmaceutical ingredients (APIs). For example, CMS in the ANPRM notes that ASPR recently entered into a contract to purchase $136 million in domestically produced nitrile gloves (p. 3854). Incentivizing manufacturing through these types of contracts will be a critical step in truly bolstering the domestic supply chain.

POTENTIAL ESTABLISHMENT OF A PUBLICLY REPORTED HOSPITAL DESIGNATION REFLECTING MEDICARE PARTICIPATING HOSPITALS' COMMITMENT TO PROCURING DOMESTIC PPE AND ESSENTIAL MEDICINES

CMS seeks comments on creating a publicly reported "Secure American Medical Supplies" designation, which would be used by Medicare and potentially other payers to identify hospitals that incur higher costs to purchase domestically produced PPE and essential medicines. Hospitals that purchase a "sufficient amount" of domestically produced PPE and essential medicines could receive such a designation (p. 3853). Key questions about the designation remain unanswered, including the minimum percentage that must be met to obtain the designation, and which products would be considered American-made. As outlined below, the AAMC opposes the use of a designation because of its potential to be misinterpreted by the public and because it would preclude hospitals that are unable to meet percentage thresholds from receiving payment adjustments for their costs even if they made significant investments into purchasing domestically produced PPE and essential medicines.

[3] ASPR. https://aspr.hhs.gov/ibx/Pages/default.aspx.

Challenges to Domestic Purchasing and Health System-Specific Circumstances Could Hinder the Ability to Meet Established Thresholds

There are multiple reasons that a hospital might be unable to meet specific domestic purchasing thresholds that do not reflect a lack of commitment to purchase domestically produced PPE and essential medicines. Large academic health systems purchase through centralized supply chain functions and group purchasing organizations (GPOs), which negotiate contracts with manufacturers on their member hospitals' behalf. More than 95 percent of U.S. hospitals use GPOs to purchase drugs, devices and medical supplies.[4] When working with GPOs to purchase medical supplies and essential medicines, it is typical for health systems to make purchasing decisions through multi-year contracts that are negotiated at the health system level. These contracts cover multiple hospitals within the same health system, ensure standardized products across facilities within a system, and contain negotiated pricing and supply commitments. Academic health systems often standardize purchases of drugs and supplies across physical locations and faculty practices within the system to ensure consistency across the health system. Standardization benefits hospitals and ensures patient safety by ensuring clinical familiarity with products, reducing medication and medical device errors, and simplifying training for residents, nurses, and trainees.[5] Shifting suppliers and changing procurement decisions is therefore difficult when multi-year contracts are involved or when academic health systems have standardized procurement processes already in place. Without accounting for these reasons and nuances that might explain the inability to meet the predetermined thresholds, a publicly reported designation would be misleading and not provide meaningful information.

CMS should consider the effect of external factors, such as demand spikes, product shortages, emergencies, and natural disasters on domestic supply and the ability of hospitals to receive the designation. These phenomena were on display during the COVID-19 pandemic, when the health care sector had to rapidly adjust its procurement processes to build supply of critical diagnostic and testing supplies, medicines, and PPE, which were often in shortage due to the demand spikes driven by the pandemic. Natural disasters and other disruptions to the supply chain demonstrate the need for flexibility in the supply chain and not to over rely on one source. We emphasize that it is impossible to get an accurate picture of future demand, particularly as demand spikes and supply disruptions—either in local markets or nationally—can occur in the event of natural disasters, manmade disasters, and pandemics. This unpredictability in future demand also underscores the need for diverse sources of goods, both foreign and domestic. As an example, damage from Hurricane Helene to just one domestic manufacturing plant of IV fluids severely disrupted the health supply chain, causing nationwide shortages of the IV fluids, requiring the postponement and cancellation of surgeries, and ultimately taking nearly a year to resolve.[6]

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[4] Dean EB, Pierre R, Carter S, Bond AM. Role of supply chain intermediaries in steering hospital product choice: Group Purchasing Organizations and biosimilars. Health Aff Sch. 2024 May 15;2(6).
[5] Hopkins Medicine. Creating Consistency Through Standardization. March 24, 2018.
[6] NPR. Shortage of IV Fluids Leads to Canceled Surgeries. October 30, 2024. Food and Drug Administration. A Statement from FDA Commissioner Marty Makary, M.D., M.P.H.: Announcing Resolution of the IV Saline Solutions Shortage. August 8, 2025.

Ensuring similar shortages do not occur for other medical goods requires a diversified supply chain.

Receipt of Payment Adjustments Should Not be Tied to Whether a Hospital Obtains the Designation

While the AAMC agrees with the need for a diversified supply chain, we hold reservations for the use of a mandatory designation. It is critical that if the agency moves forward with proposing and finalizing a designation that it be voluntary and does not result in the exclusion of other hospitals that purchase domestically produced products from receiving a payment adjustment. Due to the binary nature of the designation as outlined by CMS, hospitals that make good faith efforts to procure domestically produced PPE and medicines but are unable to meet a minimum percentage threshold would be unable to receive payment adjustments to cover the higher costs related to purchasing these products. Instead of incentivizing purchasing of domestically produced PPE and essential medicines, this approach would be counterproductive, in effect penalizing those hospitals that have invested significant resources in boosting their purchasing of domestic products but ultimately fail to meet the threshold. Factors beyond the hospital's control, such as supplier issues, drug or supply shortages, existing contracting provisions, or emergencies that necessitate a sudden change in suppliers, could affect the ability of a hospital to meet percentage thresholds. If a hospital were to fall short of meeting the required thresholds for any of these reasons, these nuances would not be captured in the designation. Such a hospital would have incurred significant costs related to procuring domestically produced PPE and essential medicines but would receive no additional reimbursement to cover the higher costs of these products.

CMS Should Clarify the Intention of a Designation Beyond Being Used for Payment Purposes

CMS' rationale for the publicly reported designation is for Medicare to identify the hospitals that would receive a payment adjustment to their Medicare inpatient and outpatient payments to account for their higher costs. However, CMS does not need to create a public designation that would be posted on a website to determine which hospitals purchase domestic PPE and essential medicines. Having a designation posted on a website would likely be used, analyzed, and scrutinized by a much broader range of stakeholders. If used incorrectly, the information on designated hospitals could end up being confusing and could mislead patients and the public. This public information could end up being used to make misleading comparisons between hospitals that have very different procurement processes and institution-specific circumstances that are not explained on the website.

If CMS ultimately establishes a publicly reported designation identifying hospitals that meet domestic sourcing thresholds for PPE and essential medicines, the AAMC encourages CMS to carefully consider how this designation would be presented to the public. Having a publicly reported designation posted on a website could invite scrutiny from the public or be interpreted as representing differences in clinical quality or patient safety across hospitals. Procurement decisions, which are important for establishing supply chain resiliency, do not necessarily

correlate with hospital quality, patient safety, or health care outcomes. Therefore, CMS should clearly communicate that the designation represents supply chain practices rather than measures of quality or safety. Without the additional context explaining why a hospital is unable to meet the thresholds and the complexity involved in procurement decisions, having a designation could be misleading to the public.

POTENTIAL SEPARATE MEDICARE PAYMENT TO ''SECURE AMERICAN MEDICAL SUPPLIES'' FRIENDLY HOSPITALS

In the calendar year (CY) 2023 Outpatient Prospective Payment System (OPPS) final rule, CMS established payment adjustments under the OPPS and Inpatient Prospective Payment System (IPPS) for hospitals that purchase domestically produced NIOSH-approved and FDA-certified surgical N95 respirators. These adjustments are intended to cover the marginal costs associated with higher acquisition costs of domestically produced surgical N95 respirators. The adjustments are non-budget neutral in the IPPS and budget neutral in the OPPS. To qualify for a payment adjustment under CMS' current policy, a hospital must provide a written statement from the manufacturer of the surgical N95 respirator, certifying that it is domestically produced, and must report additional cost information on the Medicare cost report. This supplemental cost report information is then used to calculate the payment adjustment at the hospital level.

In the ANPRM, CMS seeks comments on adjusting IPPS and OPPS payments to hospitals that receive the "Secure American Medical supplies" designation. **The AAMC supports a payment adjustment that will cover the higher costs associated with purchasing domestically produced PPE and essential medicines, but we do not believe it should be tied to minimum thresholds or to a publicly reported designation. Additionally, a payment adjustment should be crafted in a way that incorporates the following considerations.**

CMS Should Implement Payment Adjustments in a Non-Budget Neutral Manner

CMS notes that an IPPS payment adjustment could be non-budget neutral (p. 3866) but that OPPS adjustments are budget neutral. As the association has recommended to CMS in previous comments,[7] we urge the agency not to apply payment adjustments under the OPPS in a budget neutral manner. Rather, we urge CMS to find an alternative authority for subsidizing the purchase of domestically made PPE and essential medicines that does not require an offsetting reduction in OPPS payments. As CMS looks to expand the scope of the adjustments, the budgetary impact and corresponding offsets will increase, so it is imperative that payment for hospitals for other OPPS services not be decreased through a budget neutrality adjustment.

CMS' Payment Adjustment Methodology Should Minimize Reporting Burden on Hospitals

Under CMS' current approach for calculating the payment adjustment, it provides biweekly interim payments based on the estimated unit cost differential between domestic and non-

[7] AAMC Comments to CMS on CY 2023 OPPS Proposed Rule.

domestic surgical N95 respirators. After a hospital submits supplemental cost report information for the year in question related to the costs of purchasing domestic N95 respirators, CMS will settle payments for each hospital at cost report reconciliation. This approach requires hospitals to report detailed information on a supplemental cost report form related to the quantity and costs of domestic and non-domestic respirators, as well as IPPS and OPPS payments to the hospital for domestic respirators. CMS is seeking comments on whether to modify this methodology to instead pay based on a national standard unit cost differential between domestic and non-domestic PPE and essential medicines. The AAMC supports this approach, which would reduce burden on hospitals and avoid the need for retrospective reconciliation of payment adjustment amounts. By shifting to a national standard unit cost differential, CMS would not need to collect information from hospitals through additional information on the Medicare cost report. Notably, the Medicare Payment Advisory Commission, noting the burden associated with the hospital-specific approach, recommended that CMS consider using a national cost differential.[8]

In addition to using a national cost differential, CMS should accurately account for additional costs associated with purchasing and using domestically produced PPE. For example, when a provider changes suppliers and products, there are costs associated with testing and appropriately using the new products, including training staff on their use, and in the case of PPE such as N95 respirators, conducting fit testing. CMS should ensure that these costs associated with changing procurement processes and suppliers are included in calculating the cost differential.

CMS Should Provide a List of PPE and Essential Medicines that Qualify as Domestically Produced

CMS seeks comments on difficulties with its current requirement that hospitals rely on a written attestation from the manufacturer that a certain NIOSH-approved surgical N95 respirator is domestically produced. Among the areas for feedback, CMS asks whether having a publicly available list of eligible products and not requiring hospitals to obtain a written statement from the manufacturer would incentivize more hospitals to utilize the payment adjustment. The AAMC encourages CMS to work with the relevant government agencies, such as NIOSH and the FDA, to create a publicly available list of domestically produced PPE. This approach would remove from the hospital the burden of determining whether PPE or medicines are domestically produced and allow it to cross-reference the list prior to making decisions on which products to purchase. Furthermore, removing the requirement to obtain a written statement from the manufacturer would streamline the process of purchasing eligible supplies and could encourage uptake of the payment adjustment.

Expansion of Payment Adjustment to Other PPE

CMS' current payment adjustment applies specifically to NIOSH-approved domestically produced *surgical* N95 respirators—that is, those respirators that also have the added protection

[8] MedPAC Letter to CMS on CY 2023 OPPS Proposed Rule. https://www.medpac.gov/wp-content/uploads/2022/09/09122022_OPPS_FY2023_MedPAC_COMMENT_v2_SEC.pdf.

that surgical masks provide from fluid penetration and are appropriate for use in settings such as the intensive care unit, emergency department, or the operating room. In the ANPRM, CMS seeks comment on expanding payment adjustments to other PPE, such as other types of respirators, nitrile gloves, surgical masks, gowns, syringes, needles, and catheters (p. 3855). The AAMC supports the expansion of the payment adjustment to cover other categories of PPE and urges CMS to modify the payment adjustment accordingly. Expanding the payment adjustment to other types of PPE would encourage purchase of more domestically produced PPE. Hospitals should be reimbursed for the additional cost that they are incurring by purchasing domestically made products while supply and demand balance out and costs of domestic products mitigate. Reimbursement for a broader range of PPE will be vital both during and outside of a PHE for the protection of both healthcare workers and their patients.

Evaluate Additional Root Causes Impacting the Drug Supply Chain and Implement Policies to Directly Address Them

Specific to essential medicines, the AAMC urges CMS to study the root causes of drug supply chain issues and to explore policies to address these issues. Overall, the AAMC supports CMS' efforts to ensure hospitals, providers and patients have access to needed medicines. The inability to access medications due to drug shortages negatively impact patients by adversely affecting drug therapy and potentially causing delays in medical treatments. Creating a buffer stock of essential medicines is one way to prevent inaccessibility due to drug shortages or other supply demands. The AAMC agrees with and supports CMS' assessment that an add-on payment to offset the higher cost of wholly domestically made, high-quality essential medicines could be made in a non-budget neutral manner. In addition to offsetting the potentially higher costs of domestically made drugs, health-systems and hospitals may face additional administrative and infrastructure costs to procure and properly store drugs in a buffer stock. We agree with the agency's goal of improving resiliency in the supply chain by improving domestic manufacturing. However, we also urge CMS to further investigate root causes of drug shortages and implement changes that support the entire supply chain beyond the add-on payment for an essential medicine buffer stock. There are additional challenges to increasing domestic manufacturing and ensuring a robust, reliable supply chain that may require multiple policy changes working together that go beyond the scope of CMS' current request for comment.

CMS acknowledges in the FY 2025 IPPS proposed rule there are stakeholder concerns regarding the potential for demand shocks due to expanded incentivization or requirements for establishing a buffer stock of essential medicines.[9] Initial demand shocks further strain an already fragile supply chain and do not provide manufacturers with a predictable understanding of hospital needs to be able to invest in the right amount of infrastructure and labor to keep up with demand. With this in mind, the agency must consider the impacts to the supply chain should they implement new policies to support the establishment of buffer stocks by individual hospitals or health-systems. Without carefully considering the increased demand, the sudden increase in demand may create demand shocks to the supply chain or incentivize other purchasing practices

[9] 90 FR 18002

that exacerbate drug shortages. The AAMC has previously shared additional options for policy changes to address drug shortages in response to an RFI from the Federal Trade Commission (FTC) and the U.S. Department of Health and Human Services (HHS).[10] Within this response, we urged policymakers to explore options that focus on quality and resiliency needs such as bolstering efforts to further develop a quality rating system for manufacturers, develop payment adjustments for generic essential medications frequently in shortage, and increasing supply chain transparency. Beyond incentivizing a buffer stock of essential medicines, CMS may consider these additional policy options to ensure a robust drug supply chain.

CMS further seeks comment on the use of a list of "critical components and critical items." Such a list could include parameters for what percentage of an essential medicine is produced with domestically manufactured APIs and key starting materials (KSMs) to qualify as a domestically manufactured product. Currently, CMS is considering an appropriate standard of over 50 percent of the API and the entire final dosage form (not including components such as syringes or IV bags) be manufactured in the US to qualify as domestically manufactured. (P. 3853). However, CMS notes limitations to current domestic manufacturing capacity and may modify its policy as production increases. (P.3854).

While the AAMC supports an add-on payment, it should not be limited to exclusively domestically produced medications if the goal is to ensure a robust supply of essential medicines. Keeping the options for procurements broader provides greater accessibility to these drugs, especially while domestic manufacturing is still being increased to meet potential demands. Further, health-systems and hospitals face significant difficulty in identifying which products meet the definition of domestically produced, even if manufacturers share all data. An alternative to this could be for CMS to collect information from manufacturers and maintain a list or designation for manufacturers to be certified as qualifying as wholly domestically made. Specific to CMS' request for comment on "critical components and critical items," we would support the identification of these via as list maintained by the agency. However, as CMS details, many of these APIs and KSMs are not currently domestically manufactured. CMS must consider why these products are not currently being domestically manufactured and identify the key drivers to better identify pathways to support domestic manufacturing and ensure enough demand to maintain the onshoring of these drugs, APIs, and KSMs. Current challenges to expanding pharmaceutical manufacturing also include cost pressure, regulatory uncertainty and unintended disincentives in current policy, shortage of a skilled labor force, geographic vulnerability even domestically, and investment hesitancy. The agency should work collaboratively with other federal agencies on their goal to incentivize and bolster the domestic production of these products.

[10] AAMC, Comments to FTC and HHS on Ownership and Consolidation in Health Care (June 2024)

HOSPITAL IQR PROGRAM MEASURE

Request for Information on a Structural Measure of Domestic Procurement

CMS seeks feedback on the potential development and adoption of a structural quality measure for the Hospital Inpatient Quality Reporting (IQR) Program that would measure hospitals attesting to meeting minimum percentages for procuring domestically produced PPE and essential medicines. (p. 3856) The AAMC strongly supports the agency's goal of ensuring a more resilient health care supply chain and recognition that supply chain disruptions for critical health care supplies have the potential to significantly impact patient care. However, we do not believe a structural quality measure is an appropriate lever for this goal, as it is unclear how such a measure would serve as a quality indicator and hospitals alone should not be held responsible for domestic production of PPE and essential medicines.

Structural Measures Are a Poor Proxy for Quality of Care and Development of Such a Measure to Address Supply Chain Resiliency is Unlikely to be an Effective Tool

Structural measures are typically limited by weak correlation with actual patient outcomes and failure to predict the quality of care delivered and should only be used where other policy levers to improve patient care are not available.[11], [12] Here, supply chain resiliency, while impactful on the quality of care patients receive, is better addressed outside of quality measurement via the implementation of evidence-based solutions across multiple stakeholders, including but not limited to hospitals, to resolve. Hospital procurement is only one aspect to overall supply chain resiliency, and hospitals cannot control broader economic conditions impacting domestic manufacturing and production of critical supplies. Additionally, domestic production does not automatically mean hospitals will have access to critical supplies. Natural disasters can occur anywhere and cause shortages, as experienced in 2024 when Hurricane Helene shut down the domestic production of 60% of the intravenous solutions used in the country.[13] In such a case, hospitals could have attested to domestic procurement yet still faced shortages that impacted patient care.

If CMS were to move forward with a structural measure, the AAMC asks that CMS commit to working with technical experts and demonstrating face validity that measure-based attestations of domestic procurement correlate with patient safety outcomes. We suspect that the time and resources necessary to develop the measure and the initial testing of face validity will be significant, and that other more effective policy solutions are available. As noted previously in this letter, CMS can explore other options such as collaborating with other government agencies

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[11] T. Hayford and J. Maeda, Working Paper Series, Congressional Budget Office: Issues and Challenges in Measuring and Improving the Quality of Health Care, at 13 (2017)
[12] CMS, Measures Managements System, at 2 (2018), stating "The limitation of structural measures is that they do not measure the quality of care received or indicate whether a patient's health was improved as a result of that care."
[13] T. Murphy, Hospitals may face IV fluid shortage as N.C. factor remains shut down after damage from Hurricane Helene, PBS (2024).

to incentivize domestic production of PPE and essential medicines through bulk purchasing and contracting with domestic manufacturers.

Supply Chain Resiliency Requires All Stakeholders to be Held Accountable and Work Collectively on Evidence-based Solutions and Government Investment

Shortages of critical health care supplies and essential medicines are a complex challenge that require the implementation of evidence-based solutions across multiple stakeholders to resolve. Hospital procurement of these supplies and medicines is only one limited aspect of the overall supply chain. **A mandatory, publicly reported quality measure would place accountability on the end purchaser, rather than all actors who influence the availability of critical health care supplies.** Such a measure could have the unintended consequence of reducing, not increasing, the broad availability of critical supplies, as hospitals might feel compelled to invest more heavily in domestic production of such supplies to achieve the CMS designation, driving up prices through greater demand and increasing costs on an already cost-burdened healthcare system.

CONCLUSION

Thank you for the opportunity to comment on this ANPRM. The AAMC supports the administration's efforts to support a resilient and reliable supply chain. While payment adjustments will incentivize the uptake of domestically produced PPE and essential medicines, this approach must be coupled with a more holistic approach that involves stakeholders other than just hospitals. Publicly reported designations and structural measures do not serve CMS' ultimate goals of diversifying the supply chain and ensuring its resiliency. We would be happy to work with CMS on any of the issues discussed or other topics that involve the academic community. If you have questions regarding our comments, please feel free to contact Shahid Zaman (szaman@aamc.org), Phoebe Ramsey (pramsey@aamc.org), or Katie Gaynor (kgaynor@aamc.org).

Sincerely,

Jonathan Jaffery, M.D., M.S., M.M.M., F.A.C.P.
Chief Health Care Officer

cc: David Skorton, M.D., AAMC President and Chief Executive Officer