

# 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

March 2026

### ANNOUNCEMENTS:

#### **MedPAC Reviews Medicare Advantage and Medicare Enrollment**

The Medicare Payment Advisory Commission (MedPAC) met March 2-3 to discuss Medicare Advantage (MA), beneficiary enrollment decisions in Medicare, and Medicare Part B premiums. Commissioners began with a preliminary review of MA provider networks, finding that while most clinicians participate in these networks, their participation is not static, meaning that they may move in or out of network over time. MedPAC found that over 74% of primary care providers and 76% of specialists participate in three or more MA organizations but may move from plan to plan throughout the year, potentially creating disruption for beneficiaries. Commissioners concluded the first day by reviewing an analysis of scenarios the Centers for Medicare & Medicaid Services (CMS) could adopt to implement MA encounter data into the risk adjustment model used to determine benchmarking and payments to MA plans. On the second day of its convening, MedPAC reviewed Medicare enrollment decisions for beneficiaries, including considerations surrounding the timing of enrollment. MedPAC plans to include an informational chapter in the commission's June 2026 report to Congress. **STAFF CONTACT: Katie Gaynor, [kgaynor@aamc.org](mailto:kgaynor@aamc.org)**

#### **MedPAC Releases March 2026 Report to Congress on Medicare Payment Policy**

The Medicare Payment Advisory Commission (MedPAC) also released its [March 2026 Report to Congress \(PDF\)](#), evaluating payment adequacy and issuing payment recommendations across seven Medicare fee-for-service payment systems, including hospital and physician payments. For hospital inpatient and outpatient services, MedPAC recommended that Congress increase hospital inpatient and outpatient services by the statutorily required update for 2027. The commission also recommended that Congress transition to redistributing disproportionate share hospital and uncompensated care payments as an add-on payment to both inpatient and outpatient payments using the Medicare Safety-Net Index (MSNI) as described in the commission's March 2023 report and add \$1 billion to the MSNI pool [[refer to Washington Highlights, Jan. 13, 2023](#)].

For physicians and other professional health services, commissioners recommended that Congress increase payment rates by 0.5% more than the .75% for qualified participants (QPs) and .25% for non-QPs under current law. Commissioners noted that this increase will help address the growing cost of care, improving access for Medicare beneficiaries while limiting the growth of beneficiary cost-sharing.

The report also included three status report chapters and two mandated report chapters covering Ambulatory surgical center services, Medicare Advantage, Part D Plans, the impact of recent changes on Home Health payment, and dual-eligible special needs plans.

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#### **MACPAC Reviews Prior Authorization and Accountability of Medicaid MCOs**

The Medicaid and CHIP Payment and Access Commission (MACPAC) met March 5-6 to discuss topics including automation in prior authorization, recommendations for accountability of Medicaid managed care plans, mandatory and optional spending in Medicaid, and the latest *MACStats* publication. Commissioners first reviewed the use of automation in prior authorization in Medicaid, including potential policy options. The policy options reviewed by the commission call for clarification regarding the need for clinical expertise in the review and approval of denials; guidance for state oversight of Medicaid managed care plans' use of automation tools; requirements for denial reviews to be assessed by humans with appropriate clinical experience in Medicaid fee-for-service plans; and requirements to disclose the use of automation in prior authorization in state managed care contracts. Commissioners then reviewed two draft recommendations to ensure accountability of Medicaid managed care plans. The first draft recommendation directs CMS to provide guidance on the types of accountability actions that should be reported on Managed Care Program Annual Reports and how states should

consistently report these. The second draft recommendation directs CMS to develop a publicly available database on managed care plan performance that links federally mandated reported data together and to issue guidance to states on how to effectively use these data. Lastly, commissioners reviewed MACPACs latest MACStats publication, which was released in February and includes trends and key statistics related to program enrollment, spending, eligibility, and beneficiary utilization and access to care.

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### **MACPAC Releases March 2026 Report to Congress on Medicaid and CHIP Policy**

The Medicaid CHIP Payment and Access Commission (MACPAC) also released its [March 2026 Report to Congress \(PDF\)](#) on March 12. This report contains four chapters on:

- Bolstering the home- and community-based services (HCBS) workforce.
- Behavioral health in Medicaid and CHIP.
- The role of Medicaid in supporting justice-involved youth.
- How Medicaid meets the needs of children in child welfare.

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### **CMS Releases Guidance on Changes to Medicaid Eligibility Redeterminations**

CMS released [guidance addressing the implementation of Section 71109](#) of the One Big Beautiful Bill Act (OBBBA, P.L. 119-21), which requires states to complete eligibility redeterminations once every six months, beginning with renewals starting on or after Jan. 1, 2027, for most individuals enrolled in the Medicaid adult group. Regulations before the passage of OBBBA allowed for states to redetermine eligibility once every 12 months. Specifically, CMS offered clarification on the language with respect to redeterminations scheduled on or after Jan. 1, 2027. The agency will now provide two options for states. Option one would refer to “scheduled” as a renewal initiation date and would shorten the current eligibility period to six months. Option two would refer to “scheduled” as the act of setting a future renewal initiation date and would not reschedule the current eligibility date but would apply a six-month eligibility period moving forward to the first renewal conducted in 2027.

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### **CMS Issues New Organ Transplant Guidance**

CMS issued [new guidance clarifying and reinforcing the responsibilities of Organ Procurement Organizations \(OPOs\) and donor hospitals](#). The [guidance](#) discusses responsibilities of hospitals to provide patients with complete, life-saving medical treatment without regard to potential organ donation status and to allow families time to make decisions without pressure. The guidance also notes that a subsequent declaration of death is the responsibility of the patient’s physician and not the OPO. Hospitals are reminded that they must comply with the Medicare Condition of Participation, requiring that they have clear and specific policies for all aspects of the organ procurement and transplant process.

In significant change to previous guidance, the agency will require surveyors to cite noncompliance related to federal requirements once identified, even if the issue is subsequently addressed and corrected. This action is part of a broader Health and Human Services initiative to strengthen oversight of organ procurement organizations and to advance transparency, and accountability, and patient protections across the organ donation and procurement system.

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### **COMMENT LETTERS:**

#### **AAMC Comments on 2027 Notice of Benefit and Payment Parameters Proposed Rule**

The [AAMC submitted comments Thursday \(PDF\)](#) to CMS on the Notice of Benefit and Payment Parameters proposed rule for 2027, relating to issuers offering qualified health plans (QHPs) through federally facilitated Marketplace and state-based Exchanges on the federal platform. Exchanges are entities, established under the Patient Protection and Affordable Care Act ([P.L. 111-148, PDF](#)), through which qualified individuals and qualified employers can purchase health insurance coverage in QHPs.

The AAMC's comments focused on the effect CMS' proposals would have on access and affordability and urged the agency not to finalize policies that raise costs for beneficiaries, restrict network adequacy, or hinder access to care. The AAMC asked the agency to maintain their current policy regarding network adequacy time and distance criteria and their standard for demonstrating a sufficient number and geographic distribution of Essential Community Providers to ensure reasonable access to care and allow consumers to exercise their right to choose their health insurance and provider.

Further, the AAMC urged CMS not to move forward with allowing the use of non-network plans or expanding access to non-comprehensive, high-cost catastrophic plans as a means to address patient affordability.

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#### **AAMC Responds to CMS on Fraud, Waste, and Abuse**

The AAMC submitted comments on March 26 in response to the CMS [request for information related to Comprehensive Regulations to Uncover Suspicious Healthcare \(CRUSH\)](#). The request focused on how to prevent bad actors from engaging in fraud, waste, and abuse in health care in order to protect taxpayer dollars. [The AAMC emphasized its commitment to tackling fraud, waste, and abuse \(PDF\)](#) and ensuring that Medicare and Medicaid funds are being used within the confines of the law and to benefit Medicare and Medicaid beneficiaries.

In its comments, the AAMC recommended that CMS maintain the one-year claims filing deadline for most Part A and Part B claims, limiting any tighter deadlines to high-risk actors. Comments also urged the agency to ensure states continue to have flexibility to tailor their Medicaid programs to meet the unique needs of providers and enrollees, including allowing states to use statutorily approved financing mechanisms like intergovernmental transfers and state directed payments. The AAMC further encouraged CMS to provide oversight of artificial intelligence in prior authorization and in marketing and advertising practices. Lastly, comments urged the agency not to hold providers accountable for wasteful, abusive, or fraudulent spending that is outside of their control, specifically in accountable care organizations and clinician scores under the Merit-based Incentive Payment System.

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#### **AAMC Comments on Strengthening Domestic Supply Chain of Medicines and Supplies**

The AAMC [submitted comments \(PDF\)](#) on March 26 in response to CMS' advance notice of rulemaking on strengthening the domestic supply chain of medicines and supplies. CMS sought comments on how Medicare-participating hospitals can help shore up the production and use of American-made personal protective equipment (PPE) and essential medicines [refer to [Washington Highlights, Jan. 30](#)]. The AAMC's comments support the agency's goal of increasing the purchase of PPE and essential medicines from domestic sources under the right set of circumstances.

The AAMC supported a payment adjustment that will cover the higher costs associated with purchasing domestically produced PPE and essential medicines but that it should not be tied to minimum thresholds or to a publicly reported designation. The association also asked that any payment adjustment not be made in a budget-neutral manner and should minimize reporting burden on hospitals. Lastly, the AAMC shared concerns regarding the use of a structural quality measure as an appropriate lever for this goal, as it is not clear how such a measure would serve as a quality indicator.

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#### **UPCOMING COMMENT LETTER DEADLINES:**

- **Due April 20, 2026:** Request for Information: 340B Rebate Model Pilot Program