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Association of American Medical Colleges
Statement for the Record
before the
House Ways and Means Committee
"Hearing with Health System CEOs"
April 28, 2026

The AAMC (Association of American Medical Colleges)[1] appreciates the opportunity to submit this statement for the record regarding the "Hearing with Health System CEOs" on April 28, 2026. The AAMC welcomes the chance to share the perspective of academic medicine and to work with you as you discuss making health care more affordable.

Academic health systems and teaching hospitals, in partnership with medical schools and faculty practices, are pillars of their communities and play an indispensable role in our nation's health care infrastructure. These systems often operate as hub and spoke models, with a major academic medical center at the core, and multiple, smaller "spokes" in the form of smaller hospitals, clinics, and physician offices. This model benefits patients, as they can often receive coordinated care under one system, and across a range of settings and acuity levels, while ensuring that academic medicine is accessible not just in major metropolitan centers but in communities that might otherwise lack it.

However, it is crucial to remember that urban academic medical centers, which are often at or over capacity, rely on the crucial care that is delivered in smaller facilities. In fact, when smaller hospitals or clinics face financial distress severe enough to threaten closure, it is frequently academic health systems that are called upon by those hospitals themselves, and sometimes by state governments, to step in. These are not opportunistic acquisitions; they are often the last viable path to preserving health care access for communities that have no other options. When an academic health system assumes responsibility for a struggling facility, it brings clinical resources, operational infrastructure, and financial stability that allow those hospitals to remain open and continue serving their patients. The alternative, closure, would leave those communities without access to care entirely.

At the same time, our members are also operating under extraordinary financial pressures. While financing the missions of an academic health system has always been a complex and arduous process, it has never been more difficult to operate an academic health system. The AAMC recognizes that health care costs are rising, and we want to ensure that affordability does not impact patient access to care. In fact, our members are committed to doing their part to contain and even lower the costs of health care.

[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.

As the Committee considers policies intended to address health care affordability, it is essential to understand the underlying drivers of cost growth in the health care system and the unique financial pressures that are facing hospitals that anchor the nation's health care infrastructure. Specifically, we ask the Committee to:

- Recognize and invest in the unique and costly missions of academic health systems that can drive higher but justified costs;
- Investigate and address commercial insurer practices that impose enormous administrative and financial burdens on health systems, hospitals, providers, and patients, particularly as it applies to Medicare Advantage;
- Preserve the ability for all hospitals to reclassify to an appropriate designation that suits their patient population and needs;
- Reject so-called "site-neutral" Medicare payment cuts that would disproportionately harm academic health systems and teaching hospitals;
- Reject proposals to eliminate or narrow the tax-exempt status of nonprofit academic health systems and teaching hospitals; and
- Recognize the efforts our members are making to make health care more affordable.

Academic Health Systems and Teaching Hospitals Are Facing Historic Financial Pressures, but Must Still Support Their Missions

AAMC members continue to grapple with a confluence of economic challenges. Historic workforce shortages, unprecedented capacity challenges, inadequate reimbursement from public and private payers, supply chain disruptions, rising expenses such as labor costs, significant cuts to the Medicaid program, and the looming risk of other harmful Medicare payment cuts have placed enormous strain on hospital finances.

Although AAMC-member health systems and teaching hospitals represent only 5% of all inpatient U.S. hospitals, they train 69% of residents nationwide, operate 100% of comprehensive cancer centers, 68% of burn unit beds, 56% of level-one trauma centers, and 65% of pediatric intensive care unit (ICU) beds.[2] Additionally, our members are fulfilling their research and community collaboration missions: approximately 60% of the extramural research that the National Institute of Health (NIH) funds occurs on our member campuses, and about 32% of hospital charity care nationwide is provided in our member hospitals.

Labor costs alone now account for more than half of total hospital expenses, reflecting the highly skilled workforce required to deliver safe and effective care.[3] Hospitals have also raised wages substantially in recent years in order to recruit and retain physicians, nurses, and other clinical staff amid persistent workforce shortages. At the same time, hospitals continue to face higher costs for supplies, equipment, and pharmaceuticals.

Despite these rising expenses, payment updates from public programs have failed to keep pace. According to the Medicare Payment Advisory Commission (MedPAC), hospitals' overall fee-for-service Medicare margins fell to a record low of -11.6% in 2022, and this downward trend is expected to continue.[4] The recently passed

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[2] AAMC analysis of FY2024 American Hospital Association Annual Survey Database, and the National Cancer Institute's Office of Cancer Centers, 2024. AAMC membership data, December 2025

[3] The Cost of Caring: Challenges Facing America's Hospitals in 2025, https://www.aha.org/guides-and-reports/2026-03-09-2025-cost-caring-report

[4] Medicare Payment Advisory Commission, *December 2023 Report*, https://www.medpac.gov/wp-content/uploads/2023/03/Hospital-Dec-2023-SEC.pdf.

One Big Beautiful Bill Act (OBBBA, P.L. 119-21) and the failure to extend the Affordable Care Act's Enhanced Premium Tax Credits will also pose new challenges for our members as they contend with significant Medicaid payment losses and a potential surge in newly uninsured patients. AAMC-member health systems and teaching hospitals, despite experiencing Medicare margins that average -18.2%, are continually asked to do more with fewer resources, and many are near their breaking point.[5] This is directly reflected in recent activities to offset mounting losses caused by reductions in research funding and anticipated Medicaid cuts at AAMC member institutions. Since January 22, 2025, AAMC member institutions have reported layoffs, unit closures, and hospital mergers as they attempt to maintain financial stability while continuing to serve their communities.

Caring for the Most Complex and Vulnerable Patients
In addition to providing critical primary and specialty care services, AAMC member hospitals also serve as quaternary and tertiary referral centers, meaning that they provide care for patients with the most serious, rare, and complex conditions. They care for disproportionate shares of dual-eligible, disabled, and non-white patients, and provide 27% of all Medicaid inpatient days and 32% of total charity care costs nationally, despite representing only 5% of hospitals.[6] Teaching hospitals treat four of every five Medicare transfer patients, and when a patient has a condition that no one else can treat, they come to, or are transferred to, a teaching hospital.[7] Because these patients are more complex and acute, they are more expensive to care for. In fact, AAMC data show that our members are disproportionately caring for complex patients, with an average case-mix index of 2.28 – meaning that they are treating patients with increased severity (more comorbidities, higher severity of illness, or requiring more specialized procedures) and for longer lengths of stay.[8] In fact, AAMC members' case-mix has dramatically risen since 2019, from 2.05 in 2019 to 2.28 in 2024. While costs have certainly gone up, patient complexity has similarly increased. The AAMC urges the committee to reject the disingenuous narrative that would compare costs at teaching hospitals to other care settings without accounting for the profound differences in the patients being served.

Training America's Future Physicians
Graduate medical education (GME) is the supervised, hands-on training required after medical school before a physician can practice independently. AAMC members, though just 5% of hospitals, train approximately 70% of all residents, totaling roughly 77,000 physician trainees annually.[9] They are the backbone of the nation's physician workforce pipeline, and are doing their part to ameliorate this persistent physician shortage, which is projected to reach up to 86,000 physicians by 2036.[10]

The cost of this training is staggering at nearly $26.5 billion per year, but teaching hospitals received only about 6.26 million from Medicare – roughly 24% of the total cost.[11] That leaves nearly $19 billion in unfunded training costs and requires our member institutions to identify alternative funding sources or

[5] AAMC analysis of FY2022 Hospital Cost Reporting Information System (HCRIS) released in July 2024. AAMC membership data, September 2024.
[6] AAMC analysis of FY2024 American Hospital Association Annual Survey Database, and the National Cancer Institute's Office of Cancer Centers, 2024. AAMC membership data, December 2025
[7] Association of American Medical Colleges. (2019). Investment in Teaching Hospitals Benefits all: Transfer Cases (Analysis in Brief, Vol. 19, No. 2).
[8] AAMC analysis of American Hospital Association Annual Survey Database and of MedPAR Medicare FFS claims data and AAMC membership data.
[9] Ibid.
[10] The Complexities of Physician Supply and Demand: Projections From 2021 to 2036: https://www.aamc.org/media/75236/download?attachment
[11] AAMC analysis of FY2023 Hospital Cost Reporting Information System (HCRIS) data, July 2025 release. If FY2023 data is not available, FY2022 data is used.

directly absorb those costs. Notably, 90% of AAMC-member teaching hospitals are training residents above their Medicare GME funding caps, out of sheer commitment to their communities and the future physician workforce. This commitment to training the physician workforce is unmatched anywhere else in the health care system. In fact, AAMC member health systems and teaching hospitals train roughly 80 percent of all residents being trained over the Medicare cap.[12] While private industries rely heavily on the care physicians perform and the research that they do, they fail to explicitly fund physician training.

AAMC members stand ready, however, to take on additional residents. The AAMC strongly supports the bipartisan Resident Physician Shortage Reduction Act (H.R. 4731/S. 2439), which would gradually provide 14,000 new Medicare-supported GME positions over seven years. Slots authorized by this legislation would be prioritized to hospitals in rural areas, hospitals serving patients in Health Professional Shortage Areas (HPSAs), hospitals in states with new medical schools, and hospitals operating over their caps. When fully enacted, this legislation would produce an additional 3,500 new doctors every year.

Advancing Research that Saves Lives
Approximately 60% of the research that NIH funds occurs on AAMC member campuses, and they are responsible for the foundational discoveries behind nearly every diagnostic tool, treatment, and preventive measure in clinical use today.[13] From cancer immunotherapy to Alzheimer's treatments, the breakthroughs that patients everywhere depend on trace back to research conducted in academic health systems.

This research is not cost-free for hospitals. For every federal dollar received, AAMC members contribute an additional $0.53 from institutional resources.[14] Recent reductions in federal research funding have already triggered layoffs and program closures at member institutions, jeopardizing both scientific progress and the economic vitality of research-dependent communities.

Commercial Insurer Practices Are a Primary Driver of Health Care Costs
While academic health systems struggle financially and dedicate extraordinary resources to their missions, the nation's largest commercial health insurers continue to post billions of dollars in profits annually.[15] The AAMC was pleased that the Committee previously discussed affordability with insurers in a Jan. 22 hearing, and we urge you to ensure that any action taken directly addresses commercial insurer behavior, which imposes enormous and largely hidden costs on hospitals, physicians, and patients alike.

Prior Authorization: A Costly Barrier to Care
Prior authorization is among the most burdensome and costly practices commercial insurers employ to limit care.[16] In 2023 alone, more than 50 million prior authorization requests were submitted to Medicare Advantage plans. Nearly one in nine prior authorization denials were appealed, and 80.7% of those appeals resulted in a full or partial overturn; a striking rate that suggests the vast majority of original denials were clinically unjustified.[17]

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[12] AAMC analysis of FY2023 Hospital Cost Reporting Information System (HCRIS) data, July 2025 release.
[13] AAMC analysis of FY2024 American Hospital Association Annual Survey Database, and the National Cancer Institute's Office of Cancer Centers, 2024. AAMC membership data, December 2025
[14] Academic Medicine Investment in Medical Research: Summary and Technical Reports, Association of American Medical Colleges, 2015.
[15] U.S. Health Insurance Industry Analysis Report, National Association of Insurance Commissioners, 2024: https://content.naic.org/sites/default/files/2024-annual-health-industry-commentary.pdf
[16] Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023
[17] https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-53-million-prior-authorization-determinations-in-2024/#6e420acb-2fc1-4707-8689-ac19594e493a

Some MA plans use automated algorithms and artificial intelligence to generate mass denials, only to reverse them on appeal. This process imposes devastating costs: patients face delays that worsen outcomes, and in the most tragic cases, die awaiting approval. Physicians must re-prove the medical necessity of care they have already determined is appropriate. Academic health systems and faculty physician practices employ entire teams dedicated to managing prior authorization and claims disputes, wasting resources that could have been used in the pursuit of patient care or other advancement of their missions.

The AAMC has long supported efforts to reform MA prior authorization practices, including the bipartisan Improving Seniors' Timely Access to Care Act of 2025 (H.R. 3514/S. 1816). We also applaud the Centers for Medicare and Medicaid Services (CMS) for advancing deeply needed regulatory requirements that reflect many bipartisan aspects of that legislation. We urge Congress to support further reforms that limit inappropriate denials, prohibit algorithmic overreach, and center the process around clinical judgment and patient health. These protections will become increasingly important as CMS implements the Wasteful and Inappropriate Service Reduction (WISeR) model, which will implement prior authorization in traditional Medicare in six pilot states.

Delayed and Denied Payments Impose Hidden Costs
AAMC members consistently report delayed payments, retroactive denials, insufficient reimbursement rates, and exclusion from plan networks. An American Hospital Association survey found that 50% of hospitals and health systems had more than $100 million in unpaid claims more than six months old, amounting to over $6.4 billion in delayed or denied claims system-wide.[18] While insurers hold premium dollars and collect interest, hospitals provide services and wait, or absorb losses.

Retroactive denials in which an insurer pays for care and then seeks to claw back payment months or years later are particularly destructive to hospital financial planning and patient care continuity. AAMC members must dedicate substantial administrative resources to pursue payment for care that has already been rendered and that was medically necessary. The AAMC supports the Medicare Advantage Prompt Pay Act (H.R. 5454/S. 2879), which would require MA plans to reimburse at least 95% of clean claims within 14 days for in-network services and 30 days for out-of-network care, with enforceable penalties for non-compliance and mandatory public reporting.

Rising Premiums and High-Deductible Plans are Driving Patients Away from Care
Commercial health insurance premiums rose 53% from 2014 to 2024.[19] The expiration of enhanced premium tax credits at the end of 2025 is projected to cause millions of Americans to drop coverage, increasing the uninsured rate and compounding the uncompensated care burden on hospitals. At the same time, the proliferation of high-deductible health plans has made cost-sharing so burdensome that patients frequently delay or forgo necessary care, which is a pattern that drives up long-term costs when patients ultimately seek treatment for worsened conditions.

It is insufficient for insurers to point to hospital prices as the primary driver of health care costs while simultaneously designing plans that extract maximum revenue from enrollees, deny coverage for medically necessary services, and delay payment to providers. The Committee should continue its work from its Jan. 22 hearing and pursue a full examination of insurer practices and their contribution to unaffordability.

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[18] https://www.aha.org/system/files/media/file/2022/10/Survey-Commercial-Health-Insurance-Practices-that-Delay-Care-Increase-Costs.pdf
[19] https://www.kff.org/health-costs/2025-employer-health-benefits-survey/#b80a5be7-6ddd-4d81-b9af-3126336155ca

Consolidation Among Insurers Suppresses Competition
The insurance market has grown dramatically more concentrated, giving large plans the market power to impose below-market reimbursement rates on providers and above-market premiums on consumers. A recent study found that 73% of metropolitan statistical area-level insurance markets are considered highly concentrated under federal antitrust guidelines, with 90% of those markets featuring at least one insurer holding 30% or more of commercial market share. The top three large-group insurers hold an average of 82.2% of market share in each state.[20]

Vertical integration between insurers, pharmacy benefit managers (PBMs), and pharmacies compounds these concerns. Four PBMs, all owned by major insurers, control 70% of the PBM market.[21] This consolidation enables arrangements that favor higher-cost drugs in exchange for rebates, steer patients to insurer-owned pharmacies, and exclude hospital-operated specialty pharmacies from networks. These practices raise costs for patients and undermine the value of the 340B program for safety-net providers.

The AAMC urges the Committee to investigate insurer consolidation and its effect on patient access, quality, and costs, including the role of vertical integration in health care market dynamics.

Hospitals Reclassify to Designations that Suit their Patient Population and Needs
For nearly 30 years, Medicare has permitted certain hospitals to reclassify as rural under the Inpatient Prospective Payment System when they demonstrate that they meet specific eligibility criteria. Reclassified hospitals, designated as Rural Referral Centers, access some additional, congressionally designed benefits that they earn by virtue of the patients that they serve, who come from far beyond the borders of the hospitals' immediate communities. Hospitals that apply for this status must be approved by CMS and continue to satisfy requirements to maintain their status.

Reclassification reflects the reality of delivering care today, in that rural patients do not stay within rural ZIP code boundaries when they are seriously ill. In addition to seeking much-needed primary care at AAMC-member health systems and teaching hospitals, rural patients travel to academic health systems and teaching hospitals for advanced trauma care, transplant services, neonatal intensive care, and other high-complexity services unavailable closer to home. AAMC-member health systems represent just 7 percent of IPPS hospitals, yet they treat 40 percent of all IPPS transfer cases nationwide.[22] Those patients arrive with an average case mix index of 2.58 compared to 2.01 at non-teaching hospitals, and AAMC hospitals lose $1,669 more per transfer case than per non-transfer case.[23] Geographical location does not always adequately reflect need, and payment policy should reflect where rural patients are receiving their care.

Critics falsely contend that reclassification, and particularly dual reclassification, which allows a hospital to reclassify as rural for IPPS purposes while using the Medicare Geographic Classification Review Board process to determine its wage index, harms geographically rural hospitals. That claim is not supported by how the policy actually operates. By statute and regulation, reclassifications must hold harmless hospitals that did not reclassify; as MedPAC has confirmed, an urban hospital's reclassification can increase, but cannot

[20] Guardado, Jose R. American Medical Association. Competition in PBM Markets and Vertical Integration of Insurers with PBMs: 2024 Update. https://www.ama-assn.org/system/files/prp-pbm-shares-hhi-2024.pdf
[21] Association of American Medical Colleges Research and Action Institute. Why Market Power Matters for Patients, Insurers, and Hospitals (May 1, 2024). https://www.aamcresearchinstitute.org/our-work/data-snapshot/why-marketpower-matters.
[22] https://www.aamc.org/media/10771/download
[23] Ibid.

decrease, the wage index of hospitals that did not reclassify.[24] Dual reclassification is a lawful, court-interpreted policy, and facilities utilizing it are leveraging resources made available by virtue of the patients they treat.

Proposals to restrict reclassification would not redirect resources to rural hospitals; rather, they would destabilize the academic health systems that rural patients rely on when they need care no one closer is willing or able to provide. When a critically ill patient is transferred out of a rural hospital, that transfer depends on a regional referral center with the capacity, expertise, and infrastructure to receive them. Undermining those centers does not strengthen rural health care, but rather leaves rural patients with fewer options at their most vulnerable moments. The AAMC urges the Committee to preserve rural reclassification policies and recognize that rural health care is a continuum that extends well beyond rural ZIP codes.

So-called “Site Neutral” Payment Cuts Harm Academic Health Systems and Teaching Hospitals and Limit Patient Access to Care

The AAMC strongly opposes so-called "site-neutral" Medicare payment cuts to off-campus hospital outpatient departments (HOPDs). Although teaching hospitals represent just 5% of U.S. hospitals, AAMC estimates they would bear nearly half of all payment cuts under site-neutral proposals. These cuts would occur as academic health systems are already absorbing historic Medicaid losses, reduced research funding, and negative Medicare margins.

Proponents of HOPD cuts contend that identical services should be reimbursed identically regardless of where they are delivered, but this premise fails to acknowledge that the patients treated in HOPDs are substantially more clinically and socially complex than those seen in physician offices or ambulatory surgical centers. They frequently present with multiple comorbidities, limited mobility, or conditions that require immediate access to inpatient backup and the full array of hospital resources. A physician's office is simply not equipped to manage that level of acuity, and no payment policy can change that reality.

Hospital outpatient departments also operate under far more stringent licensing, accreditation, and regulatory requirements than physician offices or freestanding ambulatory centers. Meeting those requirements carries real, ongoing costs that are appropriately reflected in Medicare’s payment structure. Site-neutral proposals ignore those structural differences entirely. Beyond the regulatory burden, HOPDs provide a range of services that simply are not available elsewhere, including outpatient drug administration for chemotherapy and other complex therapies. For Medicare beneficiaries in rural and medically underserved communities, the hospital outpatient department is often the only accessible site for these services. Cutting HOPD payments does not make those services cheaper; it makes them harder to sustain and, ultimately, harder to access.

It is also important to be clear that these cuts would reduce the resources hospitals have available to sustain essential services, support safety-net care, and fund the broader missions that make academic health systems indispensable to their communities. We urge the Committee to reject site-neutral payment cuts as a mechanism for achieving affordability. The real costs are borne by the patients who would lose access to care.

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[24] “By statute and regulation, reclassifications must hold harmless hospitals that did not reclassify; therefore, the reclassification of hospitals can increase (but not decrease) the wage index of other hospitals that did not reclassify.”
MedPAC (Medicare Payment Advisory Commission). 2023. Reforming Medicare’s Wage Index Systems. In June 2023 Report to the Congress: Medicare and the Health Care Delivery System (chapter 9, p.381). Washington, DC: MedPAC.
https://www.medpac.gov/document/chapter-9-reforming-medicares-wage-index-systems-june-2023-report/

Tax-Exempt Status is Critical to Maintaining Investments in the Missions of Academic Medicine
The AAMC strongly opposes any proposal to eliminate or narrow the long-standing tax-exempt status of nonprofit hospitals. Tax exemption is a recognition of the extraordinary public value that academic health systems and teaching hospitals provide. These institutions use the savings afforded by their tax-exempt status to sustain missions that no other type of institution can replicate: delivering advanced patient care to the most complex patients, training the next generation of physicians, conducting the medical research that drives discovery, and serving as safety nets for underserved communities.

Critics of tax exemption often focus narrowly on charity care as the benchmark for whether a hospital has earned its status. That framing fundamentally, and disingenuously, understates the breadth of community benefit that academic health systems provide. While AAMC members account for 27 percent of Medicaid inpatient days and 32 percent of all charity care costs, with a median of nearly $20 million in charity care and over $33 million in uncompensated care per hospital annually, these figures do not capture additional losses from Medicare and Medicaid underpayments, nor the cost of maintaining specialized services that communities depend on.[25] Beyond direct patient care, these institutions spend nearly $26.5 billion annually training resident physicians, with Medicare covering only 24 percent of those costs, and contribute $0.53 of their own resources for every federal research dollar received.[26] The contributions of academic health systems extend well beyond the clinic. AAMC-member institutions collectively contribute more than $728 billion to the U.S. economy, roughly 3.2 percent of GDP, and support over 7 million jobs nationwide.[27] AAMC members are research enterprises, educational institutions, and economic anchors that generate returns for their communities far exceeding the value of any tax obligation foregone.

Any serious evaluation of tax-exempt status must reckon with the financial environment in which these institutions operate. Academic health systems already face negative Medicare margins, historic Medicaid shortfalls, and the compounding pressures of the recently enacted One Big Beautiful Bill Act. The threat to tax-exempt status in this environment would not redirect resources toward patients; it would accelerate the erosion of the very institutions that provide care no one else will. The AAMC urges the Committee to reject proposals that would curtail nonprofit hospital tax exemption, and instead to work with the academic medicine community to pursue targeted, thoughtful revisions to IRS Form 990, Schedule H, that reflect a fuller accounting of the community benefit academic medicine delivers.

Academic Medicine's Commitment to Lowering Costs
While most drivers of health care costs remain outside the control of AAMC-member teaching hospitals, there are efforts academic medicine has undertaken to drive down costs.

Bending the Cost Curve by Delivering More Care in the Home
Academic medicine has been a leader in developing and implementing innovative care delivery models that improve efficiency and help lower the cost of care, including the expansion of Acute Hospital Care at Home (AHCaH) programs. AHCaH programs allow eligible hospitals to safely deliver hospital-level care to certain patients in their homes while still receiving Medicare reimbursement. Academic health systems and teaching hospitals have embraced this model as a way to provide high-quality care in a more efficient setting. By

[25] AAMC analysis of FY2024 American Hospital Association Annual Survey Database, and the National Cancer Institute's Office of Cancer Centers, 2024. AAMC membership data, December 2025.
[26] Academic Medicine Investment in Medical Research: Summary and Technical Reports, Association of American Medical Colleges, 2015.
[27] https://www.aamc.org/data-reports/teaching-hospitals/data/economic-impact-aamc-medical-schools-and-teaching-hospitals

shifting appropriate patients from high-cost inpatient beds to carefully monitored home environments, AHCaH programs help reduce the fixed costs associated with traditional hospital stays while maintaining the same clinical oversight and safety standards.

Evidence from hospital-at-home programs demonstrates that this model can significantly reduce the overall cost of care while maintaining or improving quality. Studies have found that treating eligible patients at home can lower costs per admission, often by 30 percent or more, by reducing facility overhead, shortening lengths of stay, and preventing complications that frequently occur in inpatient settings.[28] Patients receiving care at home also experience fewer hospital-acquired conditions and lower readmission rates, which further contribute to cost savings for the health system. For AAMC members that often operate at or near capacity, these programs also help ensure that inpatient resources are reserved for the most complex and critically ill patients. By improving efficiency and reducing avoidable complications, AHCaH programs represent a promising strategy for delivering high-quality care while helping to bend the long-term health care cost curve.

The AAMC is grateful that Congress extended AHCaH for five years in the consolidated Appropriations Act of 2026 and urges continued investment in the program. The AAMC urges the Committee to take steps to encourage commercial insurers to pay for more home-based hospital care.

Lowering Costs Through Advanced Alternative Payment Models (APMs)

Academic medicine and the broader health care community appreciate Congress's continued leadership in advancing value-based care through the extension of the Advanced Alternative Payment Model (APM) incentive payments included in the Consolidated Appropriations Act of 2026. This extension sends an important signal to physicians, hospitals, and accountable care organizations that Congress remains committed to supporting the transition toward payment models that reward better outcomes and greater efficiency. Advanced APMs are designed to align financial incentives with high-value care by encouraging providers to focus on care coordination, prevention, and proactive management of chronic disease. These approaches improve patient outcomes while helping reduce unnecessary spending across the Medicare program.

Evidence demonstrates that these models can generate meaningful savings while maintaining or improving quality. For example, the Medicare Shared Savings Program, which is the largest APM in Medicare, has produced billions of dollars in savings for the program, including more than $6 billion in reduced spending in 2024 alone, while consistently achieving strong performance on quality and preventive care measures.[29] These models also encourage providers to invest in innovations such as team-based care, data-driven population health management, and earlier intervention for chronic conditions, all of which help lower long-term health care costs. Academic health system participation in APMs has led to investments in telehealth innovations and home-based primary care pilots that have helped to improve outcomes and patients' access to care in the most appropriate setting, reducing unnecessary emergency department visits, inpatient stays, and readmissions.

As the Committee continues its work to examine affordability, we encourage you to build on this progress by advancing thoughtful improvements to the Medicare Access and CHIP Reauthorization Act (MACRA). In particular, we recommend modernizing financial and nonfinancial incentives to sustain participation in Advanced APMs, stabilizing Medicare physician payments with predictable annual updates that account for

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[28] B. Leff, L. Burton, S. L. Mader et al., "Hospital at Home: Feasibility and Outcomes of a Program to Provide Hospital-Level Care at Home for Acutely Ill Older Patients," *Annals of Internal Medicine*, Dec. 2005 143(11):798–808.
[29] https://www.cms.gov/files/document/fact-sheet-ssp-py24-financial-quality-results.pdf

practice cost inflation, and leveraging the Centers for Medicare & Medicaid Services Innovation Center to develop and scale successful payment models, especially those that support rural providers and improve care for patients with chronic conditions. Together, these steps will help ensure clinicians can continue investing in delivery reforms that improve care for patients while helping lower costs for the Medicare program over time.

Improving Population Health Through Education and Training
Academic medicine is committed to helping address the causes of chronic disease, which is an important step in lowering long-term health care costs. Conditions such as cardiovascular disease, Type 2 diabetes, obesity, and hypertension account for a significant share of health care spending in the United States, and academic medicine is working to ensure physicians are prepared not only to treat illness, but also to prevent it. For example, prevention, health promotion, and nutrition are integrated into the education of future physicians. Today, nearly all U.S. medical schools include required nutrition education beyond the basic sciences, a dramatic increase over the past decade. Rather than treating nutrition as a standalone topic, schools are embedding it throughout the curriculum so that physicians graduate with the competencies needed to counsel patients, work with interdisciplinary care teams, and incorporate evidence-based prevention strategies into routine care.

Academic medicine is also advancing national efforts to strengthen training in this area. The AAMC and partner organizations have convened educators, clinicians, and nutrition experts to develop competency-based frameworks and share evidence-based educational resources that can be adopted across medical schools and residency programs. Through initiatives such as national summits on nutrition education, expanded curricular competencies, and dissemination of peer-reviewed teaching materials, the academic medicine community is equipping physicians to address diet-related chronic disease through team-based, patient-centered care. While no single educational intervention on its own can fully resolve challenges with broader systemic drivers, these efforts reflect a broader commitment by medical schools and academic health systems and teaching hospitals to improve population health, reduce preventable illness, and ultimately help bend the long-term cost curve of the nation’s health care system.

Conclusion
Academic health systems and teaching hospitals are under extraordinary financial pressure. They are being asked to do more, such as train more physicians, care for more complex patients, and absorb more uncompensated care, with fewer resources and at a moment when federal funding streams are being reduced. While we support the Committee’s efforts to improve health care affordability, we urge you to consider the many drivers of these costs.

The AAMC appreciates the opportunity to offer our perspective, and we look forward to working with the Committee as you work to address health care affordability. For further questions, please contact Len Marquez, AAMC senior director, government relations and legislative advocacy, at lmarquez@aamc.org, or Ally Perleoni, AAMC director, government relations, at aperleoni@aamc.org.