

# AAMC Policy and Regulatory Roundup

*Issues that impact clinical care provided by hospitals, physicians, and other providers*



## Policy and Regulatory Updates from the Health Care Affairs Regulatory Team

April 2026

### ANNOUNCEMENTS:

#### **CMS Releases FY27 IPPS Proposed Rule**

The Centers for Medicare & Medicaid Services (CMS) on April 10 released the fiscal year (FY) 2027 Inpatient Prospective Payment System (IPPS) [proposed rule](#), with comments due June 9. CMS is proposing to increase the payment rates by 2.4% for items and services paid under IPPS for FY 2027, reflecting a projected FY 2027 hospital market basket percentage increase of 3.2%, reduced by a 0.8 percentage point productivity adjustment. The agency proposed total uncompensated care-based payments equal to \$7.46 billion (a decrease of \$250 million from FY 2026) and empirically justified disproportionate share hospital payments equal to \$3.83 billion in FY 2027.

For Graduate Medical Education (GME) updates, the rule proposes modifications to the criteria for new residency programs based on a determination of at least 90% of residents having no previous training experience in the specialty, with certain exceptions for matched and displaced residents and small programs accredited for 16 or fewer residents. There are also proposed modifications to the criteria for approved programs. CMS also announced Section 5506 slot redistributions — Rounds 27 and 28 — from the closure of Delaware County Memorial Hospital and Crozer-Chester Medical Center, both in Pennsylvania.

The rule proposes several changes to the inpatient quality reporting and performance programs, including new measure adoptions, measure modifications, and measure removals over varying periods depending on a given program. CMS also seeks feedback on several requests for information on quality measurement topics. Finally, the rule proposes changes to the mandatory Transforming Episode Accountability Model, which began earlier this year, and to establish a national successor model to the Comprehensive Care for Joint Replacement (CJR) model that ended in 2024. The proposed national model would be called CJR-Expanded and would begin FY 2028, if finalized.

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#### **CMS Releases CY27 MA and Part D Policy and Technical Changes Final Rule**

CMS issued the [Contract Year \(CY\) 2027 Medicare Advantage \(MA\) and Part D Policy and Technical Changes final rule](#) on April 2. In the final rule, the agency finalized proposed changes to the Star Rating measures, including removing the Excellent Health Outcomes for All reward and 11 measures focused on administrative processes. The agency also finalized changes to Medicare Part D plans required under the Inflation Reduction Act. These include eliminating the Part D coverage gap phase, reducing the annual out-of-pocket threshold, and removing cost-sharing for enrollees in the catastrophic phase. Some of the finalized policies related to MA involved removing the requirement for MA plans to send mid-year notices to beneficiaries about unused supplemental benefits and rolling back certain health equity requirements, including those related to MA utilization management committees and MA quality improvement programs. Several requests for information were also included in the proposed rule [refer to [Washington Highlights, Dec. 5, 2025](#)]. While CMS did not respond to comments directly, the agency acknowledged that these comments will be considered in future rulemaking.

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#### **CMS Releases CY 2027 Medicare Advantage and Part D Rate Notice**

CMS released the [Calendar Year \(CY\) 2027 Medicare Advantage \(MA\) and Part D Rate Notice](#). The Rate Notice, issued annually, issues updates to MA payment rates and finalizes technical updates to keep MA payments up-to-date and accurate. The CY 2027 rate notice included an effective growth rate of 5.33%, up from the 4.97% included in the Advance Notice. When coupled with additional changes to Star Ratings and changes to diagnostic sources, there is an expected

average increase of 2.48%. This is a dramatic increase from the 0.09% average change expected in the Advance Notice. This is largely due to CMS not moving forward with the proposal to update the MA risk adjustment model; specifically, the agency will not update from a 2018 and 2019 data set on diagnoses and expenditures to one based on 2023 and 2024 data. CMS may revisit this in future rate notices; however, it is moving forward with excluding diagnostic information from unlinked chart review records as diagnostic sources allowed for risk adjustment in CY 2027. Based on these changes, plans are projected to receive an increase of over \$13 billion in payments to MA plans in CY 2027.

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### **MedPAC Reviews Medicare Payment Incentives, Pharmacy Access, and Medicare Advantage**

The Medicare Payment Advisory Commission (MedPAC) met on [April 9 and 10](#) to discuss improving payment incentives, preferred networks, and pharmacy access in Part D, and the relationship between Medicare Advantage (MA) enrollment and hospital finances.

Commissioners began by reviewing payment incentives in Medicare Fee-for-Service, MA, and alternate payment models, including potential future recommendations to improve these incentives. MedPAC will plan to include a chapter on this work in its 2026 Report to Congress. Commissioners then continued their review of the status of regional benchmarks and benchmark plan availability in the prescription drug plan market. This was followed by the commissioners' review of trends in pharmacy access and preferred networks in Part D plans, including the effect of pharmacy closures on Part D networks. MedPAC plans to convene focus groups with pharmacists in the next cycle to constitute this work. Lastly, commissioners reviewed the estimated association between MA enrollment and provider financing in the hospital and post-acute care settings. MedPAC found no statistically significant correlation between MA penetration and all-payer margins for hospitals or post-acute care providers. They did find, however, that MA inpatient stays tended to be longer, and greater enrollment in MA may lead to a misalignment in uncompensated care payments. MedPAC will include a chapter on this analysis in the June 2026 report to Congress.

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### **MACPAC Reviews Work Requirements, Prior Authorization, and Program Integrity**

The Medicaid and CHIP Payment and Access Commission (MACPAC) met [on April 9 and 10](#) to discuss topics including the implementation of work requirements, automation in prior authorization, Medicaid program integrity, and pharmacy benefit managers.

Commissioners began the meeting by reviewing a draft recommendation on the implementation of community engagement (or work requirements), which commissioners will vote on in May for inclusion in the June 2026 report to Congress. The draft recommendation directs CMS to develop a plan for monitoring and evaluating community engagement requirements in Medicaid and to allow for transparency through the timely publication of state reporting, monitoring, and evaluation results while minimizing administrative burden. MACPAC continued its evaluation of the automation of prior authorization and reviewed four draft recommendations to ensure a human with the appropriate expertise is in the loop, and that there is adequate oversight and reporting of automation tools in plans' coverage and prior authorization processes. The commission will include a chapter on automation in prior authorization in its June 2026 report to Congress. Lastly, commissioners reviewed the role of pharmacy benefit managers, including recent legislative changes at the federal and state levels. MACPAC plans to publish an issue brief on the topic in the future.

Commissioners voted and supported a recommendation to direct CMS to provide guidance on how to report accountability actions in the Managed Care Program Annual Report. Lastly, commissioners reviewed fraud, waste, and abuse in Medicaid, finding that while this may account for a small portion of program spending, the scale and impact are difficult to quantify. MACPAC identified federal-state collaboration and program integrity in managed care as areas for additional investigation. MACPAC staff will return next cycle with additional findings following stakeholder interviews.

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### **COMMENT LETTERS:**

#### **AAMC Comments on 340B Rebate Model RFI, HRSA Burden Estimates**

The [AAMC submitted comments \(PDF\)](#) on April 20 to the Health Resources and Services Administration (HRSA) in response to the agency's request for information (RFI) on a 340B Rebate Model Pilot Program. HRSA sought input on the administrative costs to 340B covered entities of participating in a rebate model program, in addition to operational and

compliance considerations related to implementing a rebate model program [refer to [Washington Highlights, Feb. 13](#)]. Separately, the [AAMC submitted comments on HRSA's information collection request \(PDF\)](#) (ICR) to provide feedback on the agency's estimates of the burden a 340B rebate model program would impose on 340B-covered entities.

In response to the RFI, the AAMC opposed the use of rebate models in the 340B program 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 Drug Pricing Program and AAMC members, including delays in the ability of 340B hospitals to receive critical 340B savings and substantial administrative costs on 340B hospitals.

Responding to the ICR, the AAMC noted that HRSA's estimates of the total annual burden per respondent, which amounts to five hours per week, significantly understates the actual time that 340B hospitals will spend on submitting claims data and complying with the requirements of a 340B rebate model. The AAMC urged HRSA to work with 340B program stakeholders to more accurately understand the time and resources required to comply with a 340B rebate model program.

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

**Due June 9, 2026:** Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes

**Due June 15, 2026:** Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability Standards and Prior Authorization for Drugs for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges

#### **UPCOMING WEBINAR:**

##### **Fiscal Year (FY) 2027 Inpatient Prospective Payment System Proposed Rule - May 12 at 3PM EDT**

During this 90-minute webinar, AAMC staff will present on hospital payment, graduate medical education, and quality provisions from CMS's Fiscal Year (FY) 2027 Inpatient Prospective Payment System (IPPS) proposed rule. Participants will have the opportunity to ask questions once the presentations have concluded.

**Register:** [https://aamc.elevate.commpartners.com/p/260512\\_ProposedRule](https://aamc.elevate.commpartners.com/p/260512_ProposedRule)