

AAMC Clinical Care 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

May 2026

ANNOUNCEMENTS:

AAMC Reacts to Proposed Rule on SDPs and Other Supplemental Payments

The AAMC issued a May 21 statement opposing provisions of a proposed rule issued by the Centers for Medicare & Medicaid Services (CMS). In the statement, the association outlined concerns about the rule's negative impacts on access to care and urged the agency to withdraw the proposed provisions that go beyond the statutory framework established in the One Big Beautiful Bill Act (OBBBA, P.L. 119-21, PDF). In the May 20 proposed rule related to Medicaid managed care state directed payments (SDPs) and fee-for-service (FFS) supplemental payments, the CMS seeks to implement Section 71116 of the OBBBA [refer to Washington Highlights, July 3, 2025]. The OBBBA reduces the total payment rate for new SDPs, while grandfathering payment rates for existing SDPs until 2028. This rule builds on the CMS' most recent guidance from February [refer to Washington Highlights, Feb. 6]. The proposed rule goes beyond what was originally required by the OBBBA in several ways, proposing additional limits on SDPs and on targeted Medicaid practitioner payments used in Medicaid FFS. In the rule, the agency proposes to extend the OBBBA's restrictions on SDPs to all services, as opposed to the four main categories outlined in the law. Further, the rule proposes to eliminate the use of uniform rate increases as a permissible type of SDP, beginning Jan. 1, 2028. The rule also proposes to extend the OBBBA's new limits on SDPs, set at 100% of the Medicare rate for Affordable Care Act (ACA) expansion states and 110% in ACA non-expansion states, to additional types of Medicaid supplemental payments, including targeted Medicaid practitioner payments under FFS. The rule will be open for a 60-day comment period with comments due on July 21.

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HRSA Releases Rural Residency Planning and Development Grant Opportunity

The Health Resources and Services Administration (HRSA) on May 1 released a Notice of Funding Opportunity for a new round of Rural Residency Planning and Development (RRPD) grants (PDF). In this round, HRSA will award 15 grants of up to \$750,000 dispersed over three years. RRPD grants pay for the startup costs associated with opening new rural residency programs or rural track programs where greater than 50% of training takes place in a rural area. Awardees have access to technical assistance and other resources to help with the development of new programs. Eligible specialties include family medicine, internal medicine, psychiatry, general surgery, preventive medicine, obstetrics, and gynecology, including family medicine with enhanced obstetrical training. Applications are due to HRSA by June 2.

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MACPAC Votes on Final Recommendations, Reviews Work Requirements and Automation

The Medicaid and CHIP Payment and Access Commission (MACPAC) met May 7 to discuss topics including the implementation of community engagement requirements (also known as work requirements) and automation in prior authorization, as well as vote on recommendations for the commission's June report to Congress. Commissioners began the meeting with a presentation of four draft recommendations for the use of automation for prior authorization requests in Medicaid. The four recommendations presented would clarify federal requirements for oversight of prior authorization processes, ensure oversight of prior authorization processes in Medicaid Fee-For-Service, urge CMS to issue guidance to states and Medicaid plans on oversight of automation in prior authorization, and increase transparency into managed care plans' use of automation. Commissioners also reviewed a draft recommendation on implementing community engagement requirements in Medicaid. This recommendation would direct the CMS to develop a transparent plan for monitoring and evaluating community engagement requirements in Medicaid based on stakeholder input to make public a plan with meaningful metrics for tracking eligibility and enrollment. The MACPAC commissioners unanimously voted in support of the four recommendations related to automation in prior authorization. However, in the vote for the draft recommendation on implementing community engagement requirements in Medicaid, 15 commissioners voted in favor and two voted against the recommendation. These recommendations will appear in MACPAC's June 2026 report to Congress.

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CMS Finalizes 2027 Notice of Benefit and Payment Parameters Final Rule

CMS on May 15 released the Notice of Benefit and Payment Parameters 2027 final rule (PDF). This final rule contains policies aimed at issuers offering qualified health plans (QHPs) through federally facilitated exchanges (FFE) 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 employers can purchase health insurance coverage in QHPs. The AAMC previously shared comments in response to the proposed rule [refer to Washington Highlights, March 13]. The rule finalized several proposals related to eligibility, enrollment, and benefit design, including allowing nonnetwork plans to serve as a QHP through the FFE beginning in plan year (PY) 2028, increasing eligibility for noncomprehensive, high-cost catastrophic plans, allowing for multiple consecutive plan years (up to 10) as well as changes to cost-sharing parameters for catastrophic plans and individual market bronze plans, and removing time and distance standards from network adequacy standard requirements for state exchanges and state-based exchanges on the federal platform that are at least equal to QHPs participating in the FFEs. The CMS did not finalize its proposal to reduce the standard for demonstrating a sufficient number and geographic distribution of Essential Community Providers (ECPs). The proposal would have reduced the minimum percentage of ECPs that must be contracted within each plan's service area from 35% to 20%. The AAMC supports the higher minimum percentage and asked the CMS not to finalize this proposal in its comments on the proposed rule.

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USCIS Announces Change in Adjustment of Status Policy for Green Card Applications

The U.S. Citizenship and Immigration Services (USCIS) on May 22 announced a change in how it will decide adjustment of status (or green card) applications filed within the United States. As outlined in policy memorandum PM-602-0199 (PDF), the agency will now approve applications to adjust to green card status within the United States only as a matter of “extraordinary relief” and an act of “administrative grace,” effective immediately. Per the announcement, applicants should prepare to obtain green cards by applying at a U.S. consulate abroad.

While the adjustment of status path to a green card within the United States remains in place, it is anticipated to become significantly more challenging under the newly announced policy. Prior to this policy update, the vast majority of lawful permanent resident (LPR), or green card, applicants became green-card holders through filing an “adjustment of status” application with the USCIS while the applicant remained in the United States.

It is anticipated that most foreign national academic health system community professionals will not lose work authorization or legal status, even if this policy is to be applied with full and immediate force. The AAMC is continuing to monitor further guidance and statements from the administration as to how this new policy will operate in practice.

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CMS Finalizes Updates to Organ Transplant Model

CMS released a final rule on May 28 to update policies for the mandatory Increasing Organ Transplant Access (IOTA) Model for its second performance year, beginning July 1. In response to stakeholder feedback, including comments submitted by the AAMC [refer to Washington Highlights, Feb. 13], CMS increased the low-volume threshold, modified policies for updating the composite graft survival rate, and maintained the maximum upside payment amount, among other policy changes. The agency also clarified and updated policies regarding transparency and beneficiary protections.

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Final Rule Issued to Streamline No Surprises Act Dispute Resolution

The Departments of Health and Human Services, Labor, and Treasury, and the Office of Personnel Management on Thursday issued a final rule aimed at making the federal Independent Dispute Resolution (IDR) process under the No Surprises Act more efficient and transparent. The No Surprises Act (P.L. 116-260), which is designed to protect patients from unexpected medical bills, created an arbitration process to resolve out-of-network payment disputes between payers and providers, referred to as the IDR process.

The final rule will allow for up to 50 items and services (or “line items”) to be batched in the same payment dispute. These claims may be batched when they involve a single patient on the same or consecutive dates of service billed together and when claims share the same service code. Additionally, it increases access to the IDR process by reducing the administrative fees on disputes from \$115 to \$15. The rule streamlines communication between payers, providers, and IDR entities and clarifies timelines and processes. The rule would require payers to use standardized claims codes in communications about out-of-network care, enabling providers to determine whether a particular claim is eligible for IDR. Notably, the Centers for Medicare & Medicaid Services announced plans to launch a new, centralized platform for monitoring IDR disputes, called IDR Gateway. This tool will enable users to initiate a dispute, track the status of open cases, and manage other activities. The AAMC supported many of these changes in its comments (PDF) on the proposed rule [refer to Washington Highlights, Jan. 12, 2024].

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RECORDED WEBINAR:

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

During this 90-minute webinar, AAMC staff presented hospital payment, graduate medical education, and quality provisions from CMS's Fiscal Year (FY) 2027 Inpatient Prospective Payment System (IPPS) proposed rule. Register:

https://aamc.elevate.commpartners.com/p/260512_ProposedRule

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

Due July 21, 2026: Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments