



Advancing Health in America

Federal Updates

***CHA 2026 Hospital Finance & Reimbursement Conference
Oct. 20. 2026***

Topics We'll Address

- Key Themes in Washington
- Legislative Agenda
- 340B
- Medicare Payment Updates
- OBBBA Implementation
- Rural Health
- Health Plan Accountability
- Affordability

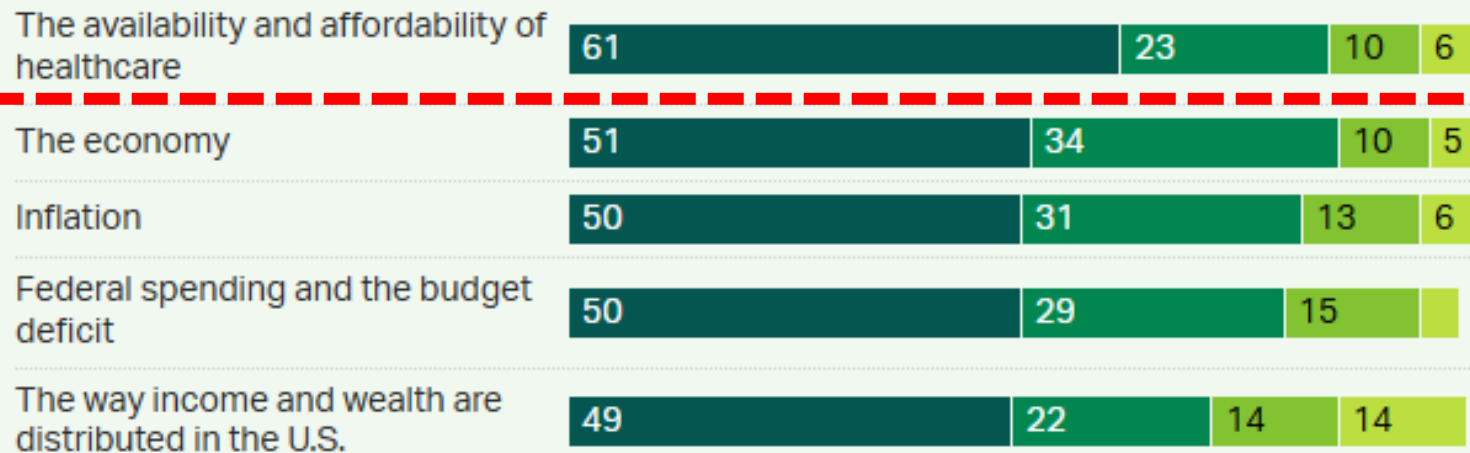
Key Themes

What's Motivating Policymakers in DC

Americans' Worries About Key Issues, 2026

Next, I'm going to read a list of problems facing the country. For each one, please tell me if you personally worry about this problem a great deal, a fair amount, only a little or not at all?

■ % Great deal ■ % Fair amount ■ % Only a little ■ % Not at all



In the past 12 months:

- One quarter of U.S. adults had problems paying medical bills
- Four in ten U.S. adults have debt due to medical or dental bills

Legislative Agenda Through Year End

Lame Duck Session: Healthcare



- **“Extenders”** (through December 31, 2026)
 - Medicare Dependent Hospital (MDH) program
 - Low-volume Adjustment (LVA) program
 - Physician Reimbursement Work GPCI
 - Community Health Centers funding
 - National Health Service Corps funding
 - Clinical Laboratory Fee Schedule Payment Cuts & Data Reporting (PAMA) delay
- **Other health care issues**
 - Transparency
 - Physician payment
 - No Surprises Act

Price Transparency Legislation

Senate:

Patients Deserve Price Tags Act

- Codifies transparency for hospitals, health plans, labs, imaging, ASCs AND adds new requirements for hospitals
- Can't use price estimator tools to meet shoppable services requirement
- Must update machine-readable files quarterly
- Increased CMPs for noncompliance
- Unclear patient billing provisions; problematic advanced EOB process
- New data disclosure requirements for health plans

House:

Health Care Price Certainty for All Americans Act; Lower Costs, More Transparency Act

- Builds on bipartisan bill that passed House in 118th Congress
- Codifies transparency for hospitals, health plans, labs, imaging, ASCs
- New data disclosure requirements for health plans
- Key issues:
 - Can price estimator tools be used to meet shoppable services requirement?
 - Posting prices on hospital walls

No Surprises Act

Insurers, employers are agitating for major changes.

- Hospitals account for only 6% of disputes
- New regulations expected to help address payer concerns re: volume, eligibility
- Outstanding issues for hospitals: payment post-IDR decision, accuracy of QPA

New AHIP/BCBSA Survey Finds Providers are Flooding IDR System with Ineligible Disputes

The No Surprises Act (NSA) protects patients from surprise medical bills for emergency services, air ambulance services or services from out-of-network providers at in-network facilities. To resolve payment disputes, the law created the federal Independent Dispute Resolution (IDR) process, which applies only to “qualified IDR item[s] or service[s].”¹ Under the NSA, qualified items or services that are eligible for IDR include: out-of-network emergency services, out-of-network non-emergency services provided at an in-network facility, and out-of-network air ambulance services. There are also procedural requirements for a qualified item or service to be eligible for payment determination as part of the federal IDR process, including timing requirements, first participation in an open negotiation process, a cooling-off period, rules for batching or bundling multiple claims as a dispute and a lack of applicable state surprise billing law.

New data from AHIP and BCBSA reveal that many claims submitted to the federal IDR process are for ineligible items or services, meaning they do not meet the criteria noted above. Despite the fact that these ineligible claims did not qualify for IDR, many have resulted in mandatory payment determinations by the arbiter, i.e., the IDR entity (IDRE). Health plans identified that as much as 39% of disputes initiated in 2024 were for ineligible claims that should not have been submitted. Examples include:

- Claims for services payable under Medicare or Medicaid;
- Disputes already resolved through IDR and resubmitted;
- Disputes involving in-network providers; and
- Claims subject to a state surprise billing law.

By funneling ineligible claims into IDR, providers aim to secure binding payment determinations for services often at amounts significantly above market rates.

Under the federal process, IDREs alone are empowered to determine a disputed claim's IDR eligibility. However, because their fees

No Surprises Act

Energy & Commerce Ranking Member introduces legislation to address payer concerns.

Lower Premiums, Faster Payments Act

- Ends the independent dispute resolution (IDR) process
- Largely maintains the existing qualifying payment amount (QPA) methodology
- Beginning 2028, providers would be reimbursed at the QPA, based on the insurers' median of the contracted rates
- No option for judicial review of the QPA



340B

340B: Legislative Landscape



- **340B for Patients Act** (Discussion Draft)
 - Manufacturers could satisfy 340B obligations via upfront discount, retrospective rebate or a Secretary-run claims repository
- **SECURE 340B Act**
 - Preserves current program structure while adding a data clearing house, contract pharmacy registration, and a statutory patient definition
- **SUSTAIN 340B Act**
 - Codifies contract pharmacy protections, sunsets the Rebate Model Pilot, and sets a child-site moratorium

Proposed 340B Regulatory Policies

Proposed Cuts in OPPS

- Pay at ASP minus 33.4% (a 40% cut)
- Accelerated recoupment of \$7.8B from original policy

Mandatory Reporting to New Claims Repository in PFS

- Required submission of certain Part D claims data elements
- Failure to comply could result in revocation of Medicare billing privileges

HRSA's 340B Rebate Program



AHA filed a lawsuit on Oct. 9 seeking to halt the Rebate program taking effect.

- “New” Rebate Program is slated to start on Jan. 1
 - Conceptually the same as the original program
 - Applies to about 21 drugs instead of 10
 - All 13 manufacturers applied for participation
 - HRSA will approval manufacturers' rebate plans by Sept. 24



Unilateral Claims Data Policies

- At least 15 companies have announced these policies
 - Only Eli Lilly appears to be enforcing at this time
- Vast expansion of existing data requirements—far beyond contract pharmacies
- Hospitals report additional FTEs needed and additional IT/TPA costs
- Reduction in 340B savings and puts patient access to drugs in jeopardy
- **AHA Position:** HRSA must take action to stop these efforts and move towards a neutral, third-party clearinghouse model.

Medicare Payment Rules

Medicare: FY 2027 Final Rules

Payment Updates

Updates don't account for inflationary environment; high productivity cut

Signaled interest in post-acute payment reform

Quality Measurement

Including Medicare Advantage beneficiaries, including in P4P programs

CMS committed to digital quality measures on short timeline

CMMI Models

No meaningful changes to CJR-X model

Intends to propose future policy to encourage participation by POHs

Outstanding CY 27 Rules

Significant focus on site-neutral policies

Outpatient:

- Pay for certain imaging services at site-neutral rate
- Remove 637 services from Inpatient Only List
- Add 618 codes to ASC Covered Procedures List
- Require unite NPI for all off-campus HOPDs

Physician Fee Schedule:

- Conversion factor decrease
- MSSP revisions to facilitate ACO participation

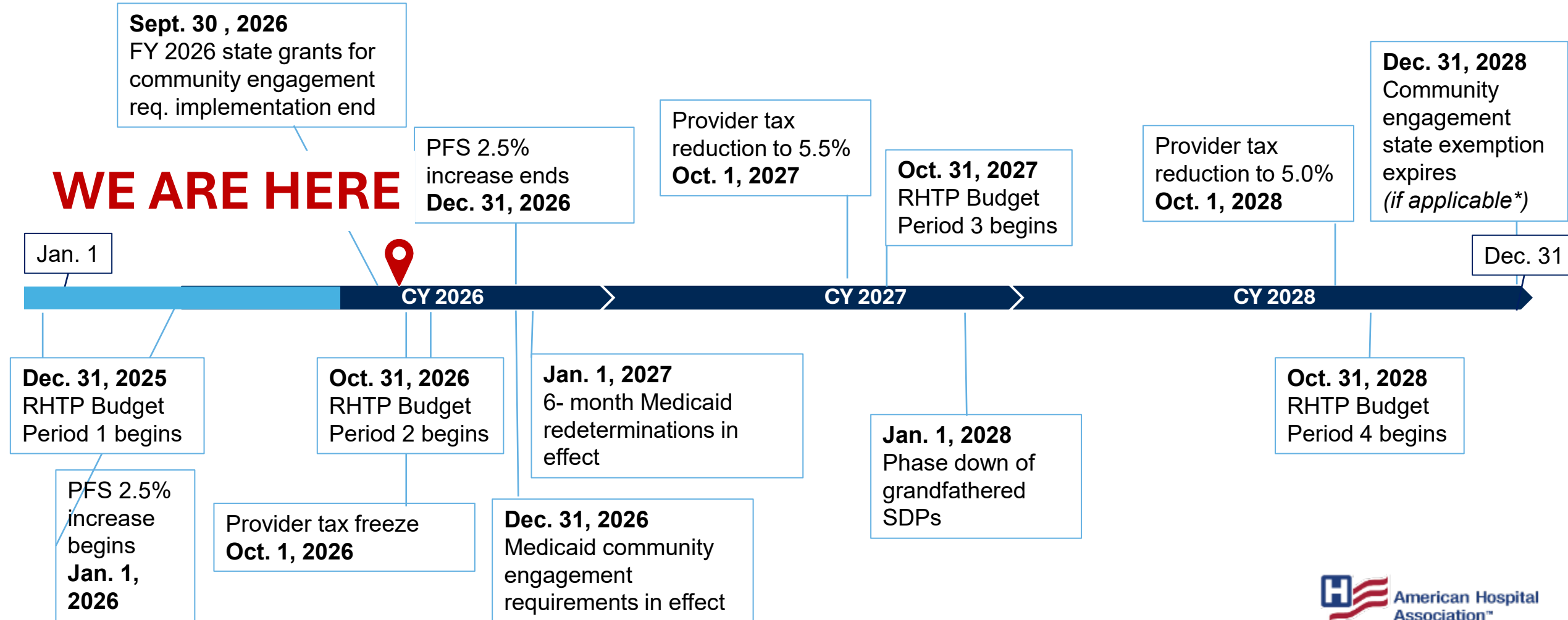
Other Topics Addressed

- RFI on price transparency
- RFI on separate IPPS payment for domestic procurement of supplies
- Revised E/M coding
- Official sunset of MIPS
- Provider enrollment requirements
- 340B

OBBBA Implementation

OBBBA Implementation Timeline

WE ARE HERE



2027 Medicaid Policy Changes

1

Community Engagement Requirements

Medicaid expansion enrollees and applicants must meet work, volunteer or education hour thresholds to maintain coverage eligibility.

2

Six-Month Eligibility Redetermination

States required to conduct eligibility reviews of Medicaid expansion enrollees every six months, a reduction from 12-months.

3

Retroactive Eligibility Limits

Retroactive coverage window narrowed, limiting back-dated eligibility for newly enrolled individuals.

4

Section 1115 Waiver Budget Neutrality Certification

New methodology for determining whether a waiver can be certified as budget neutral. Changes are expected to reduce federal outlays.

Medicaid Provider Taxes

Implications for hospital operations, state Medicaid financing

Provider Tax Proposed Rule

**Methodology
to determine
tax threshold**

**Establish
insurers as
new class of
providers**

**Plan for
monitoring
and
oversight**

**Sunset "75
75 rule"**

Rural Health

RHTP Rounds Out Year 1



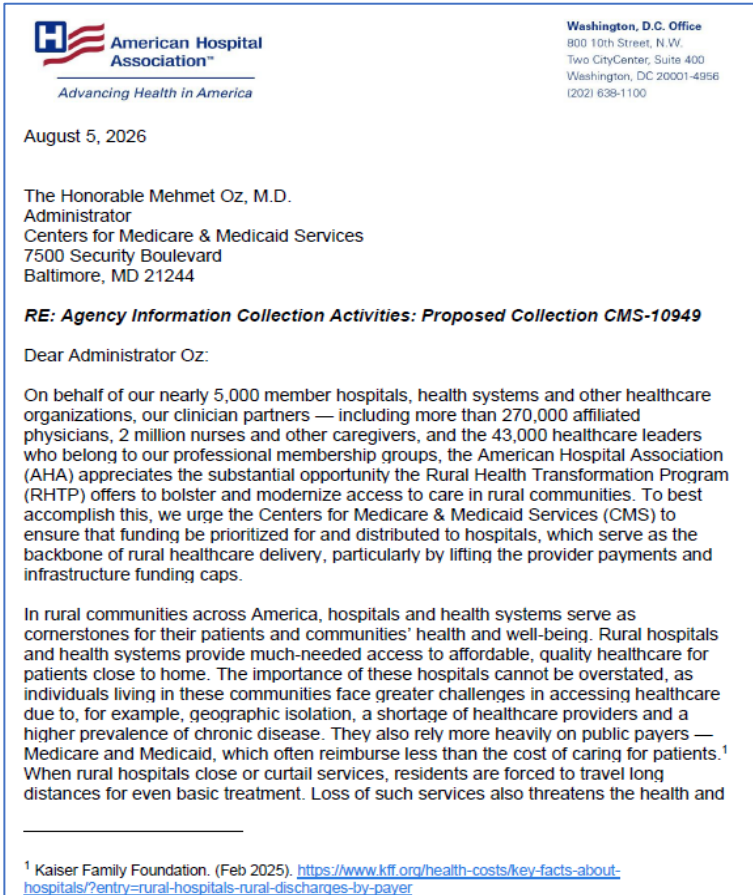
Information on awards is spotty, but appears substantial portion of funding is not going to hospitals.

- *Based on available information*, we can identify \$1.2 billion in Year 1 awards to 1,299 named-hospital award actions across 32 states
- Only 4 states have published full award information
- RHTP funding will not be able to close gaps creating by impending coverage changes

RHTP Recommendations

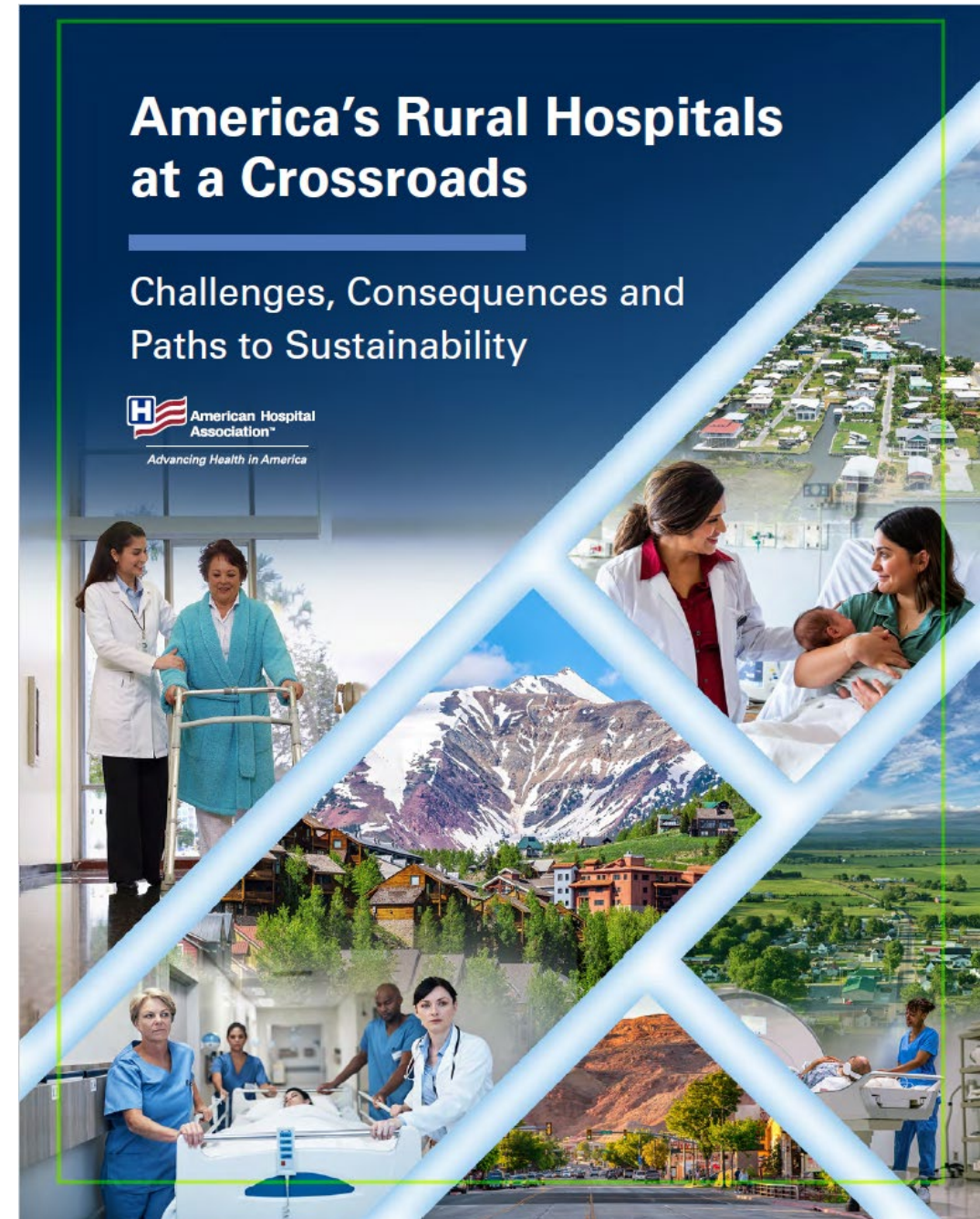
AHA Recommendations for RHTP years 2-5:

- Remove funding caps
- Revise applications and longer timeline to spend obligated funds
- Publicly post funding information states report
- Remove undue administrative burden



Rural Health Report

- More than 40% of rural hospitals lose money
- Over 150 rural hospitals have closed or converted since 2010
- Medicaid cuts could put 300+ rural hospitals at risk



Health Plan Issues & Accountability

Medicare Advantage Strategy Shift

From growth at all costs to margin recovery

Cost Control: Fewer offerings, service-area reductions and potential market exits



Primary drivers: Elevated medical cost trend, higher utilization and acuity, drug spending, and changes in risk adjustment and quality-payment dynamics



CMS-approved enrollment caps: Emerging as CY 2027 option to control growth without market exits

Health Plan Accountability

Efforts continue to address issues with prior authorization, prompt pay, downcoding and other issues.

Aetna

Level of severity

Anthem

Nonparticipating provider

Payment Integrity

Downcoding, sepsis, prompt payment, prior authorization

Evidence

Health plan oversight data

Affordability

Advancing Affordability Solutions

The AHA is positioning hospitals as leaders in meaningful solutions for patients, payers and governments.



Making Health Care More Affordable

The U.S. health care system leads the world in quality and innovation, but increasingly, patients, employers and taxpayers are finding it unaffordable.

Hospitals are the backbone of the health care system. They provide 24/7 access to the highest acuity care, train the next generation of clinicians and lead the development of life-saving innovation. They support patients and communities at every stage of life. Delivering on their unique promise to always be there to care requires resources. Even so, hospitals remain deeply committed to making health care more affordable.

Realizing genuine affordability gains will necessitate collaboration among all stakeholders, we call on purchasers, policymakers, technology companies, drug and supply manufacturers, and individuals to collaborate with us in these efforts.



What's Driving Health Care Costs?



MORE PATIENTS WITH GREATER COMPLEXITY

More people are seeking care, and they are increasingly sicker when they do — driving demand for higher-acuity services.



HEALTH CARE IS INHERENTLY HUMAN WORK

Millions of trained nurses, doctors, and technicians deliver care that cannot be easily replaced by robots or AI.



SOARING INPUT COSTS — LED BY DRUGS

Many drugs cost tens or hundreds of thousands of dollars per patient. Equipment, IT and cybersecurity costs are also rising rapidly.



ADMINISTRATIVE BURDEN & MIDDLEMEN

Limitless insurance variation forces hospitals to spend billions simply to verify coverage, obtain authorizations and process claims.



CORPORATE INSURERS SHIFTING COSTS TO PATIENTS

High-deductible health plans and growing co-insurance requirements are pushing more of the financial burden directly to patients.



INADEQUATE PAYMENT FOR ESSENTIAL SERVICES

Medicare and Medicaid pay below cost, and more than half of hospital costs tie to services where reimbursement falls short — including maternity care, behavioral health and pediatrics.

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Page 1 of 2 | aha.org





An American Hospital Association Blog

What AHA's Affordability Recommendations Mean for Patients

Jul 16, 2026 - 09:37 AM by Molly Smith - Group Vice President for Public Policy, American Hospital Association

Americans experience healthcare affordability in different ways. Often, affordability is first considered in terms of health insurance premiums that fit within an individual or family's monthly budget. However, healthcare affordability is much more — it also means being able to find care without worrying about deductibles, co-pays or unexpected bills that a patient cannot pay. It means not facing complicated and illogical prior authorization barriers that sometimes drive patients to choose to pay out-of-pocket rather than continue fighting with their health plan.

Unacceptably, millions of Americans are struggling with healthcare costs. Many have chosen to skip prescriptions or other needed care because of concerns about costs; 4 in 10 Americans have medical debt. And while avoiding care in the short-term may save some immediate expenses, this approach often results in illness and injury worsening, resulting in costlier care later.

Making Care More Affordable for Patients Is Paramount

The healthcare system writ large must do more to address patients' concerns with the cost of care. In the AHA's *"Making Health Care More Affordable: A Blueprint to Lower Costs, Improve Access and Enhance Quality,"* America's hospitals and health systems put forward several concrete ideas to reduce premiums and cost-sharing, as well as help patients avoid more complex and costly care in the future.

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10 Priority Recommendations to Improve Affordability

These high-impact recommendations address structural change in how care is financed, delivered, coordinated, and supported. They are focused on reducing total cost of care, not simply shifting costs among stakeholders.

1 Expand Access to Primary Care & Prevention

Earlier access reduces downstream spending tied to avoidable emergency department use, preventable hospitalizations and unmanaged chronic disease.

6 Reduce Administrative Friction

Eliminate unnecessary, outdated and duplicative regulatory and administrative requirements that impose cost without improving care.

2 Improve Transparency of Pricing Information

Patients need access to understandable, timely information about the cost of their care before they receive it.

7 Standardize Insurance Exchange & Claims

Uniform transactions between providers and payers would reduce duplication, lower administrative cost and speed coverage and payment decisions.

3 Protect Patients from Catastrophic Costs

Coverage and tax reforms should ensure that serious illness or injury does not push families into financial crisis.

8 Shift Patient Cost-sharing to Health Plans

Health plans are better positioned to collect cost-sharing they design — relieving providers of administrative burden and protecting the patient-provider relationship.

4 Strengthen ACOs & Value-based Care

Shift from fragmented, volume-driven care toward better outcomes at lower cost, especially for complex patient populations.

9 Increase Access to Lower-cost Generic Drugs

Expanding access to cost-effective generic alternatives reduces spending for patients, employers and public programs without compromising outcomes.

5 Reform the Medical Liability System

A more balanced liability framework reduces defensive medicine, lowers legal costs and supports high-value clinical decision-making.

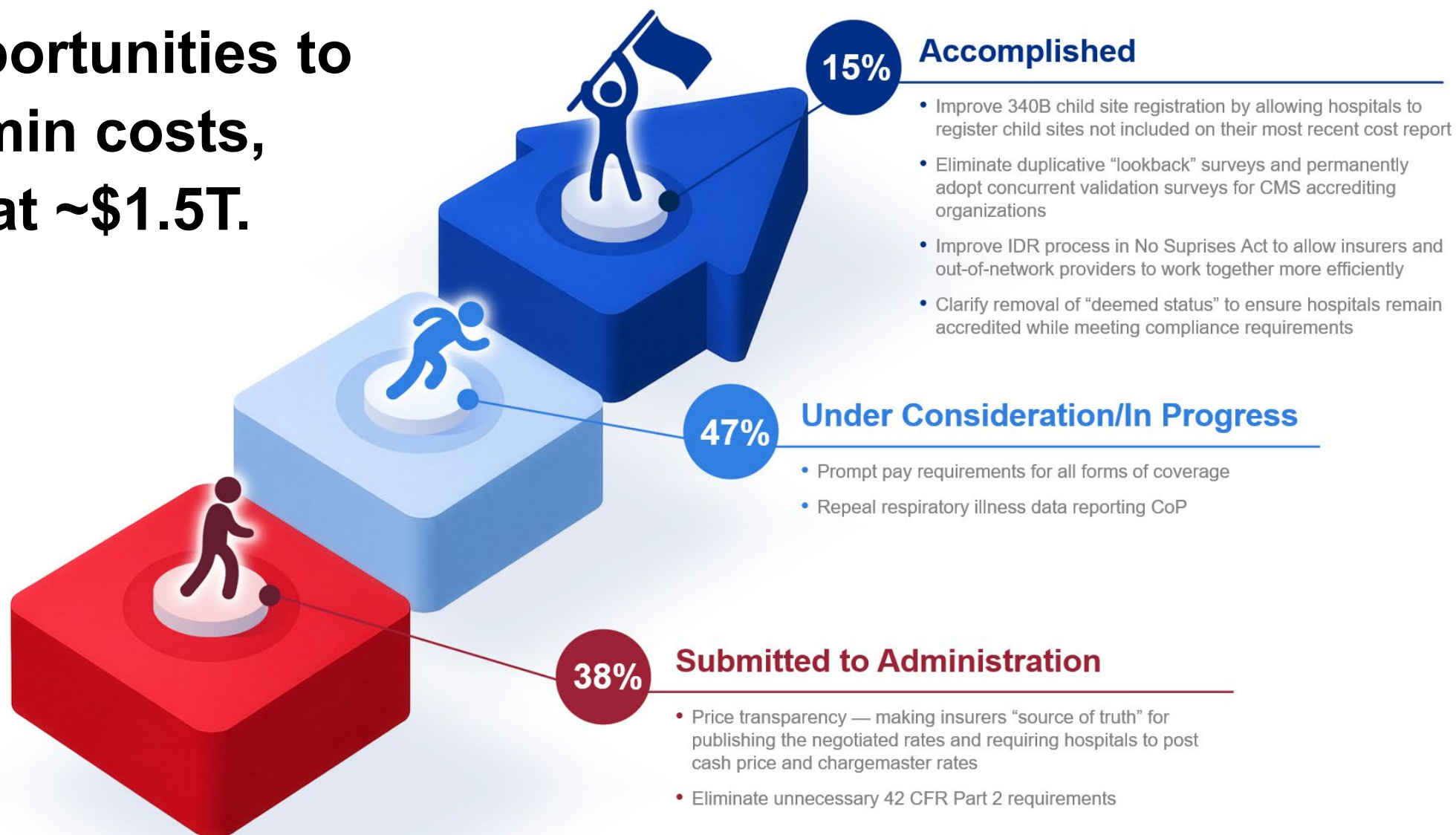
10 Expand Predictive Analytics & Early Detection

Earlier detection and intervention improve outcomes and reduce avoidable long-term costs across the care continuum.

Hospitals are committed to making health care affordable and accessible. We are providing solutions and calling on all stakeholders to work together.

Emphasis on Reg, Admin Relief

Myriad opportunities to reduce admin costs, estimated at ~\$1.5T.



Discussion & Thank You

Molly Smith
Group Vice President, Public Policy
American Hospital Association
mollysmith@aha.org