Highmark's Weekly Capitol Hill Report

Issues for the week ending February 20, 2026

Federal Issues

Regulatory

CMS Issues 2026-2027 Managed Care Rate Development Guide

The Centers for Medicare & Medicaid Services (CMS) issued the Medicaid Managed Care 2026-2027 Rate Development Guide for rating periods starting between July 1, 2026 and June 30, 2027. The updated rate guide is largely the same as the draft rate guide released in December

However, of note, CMS added language related to two of insurance industry recommendations:

- Once provision increases transparency by requiring the state and its actuary to describe the evaluation conducted, and the rationale for any applicable assumptions included or not included in rate development related to changes in Federal requirements, such as in Public Law 119-21 (see new subsection 1.A.xii on page 12).

- Another provision specifically identifies significant changes in federal requirements

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such as PL 119-21 as a potential cause of acuity differences which may permit a retrospective acuity adjustment (see section 7.A.i.b, page 56).. Read More

- **Legislative Update**

Industry Trends

Policy / Market Trends

- **Medicaid Highlights in the CBO Budget and Economic Outlook: 2026 to 2036 Report**
- **MACPAC Releases February 2026 Edition of MAC Stats**
- **AHIP Amicus Briefs in No Surprises Act IDR Abuse Lawsuit & Arkansas Pharmacy Ownership Ban Litigation**
- **DOGE Releases Open-Sourced Medicaid Claims Dataset**

CMS Issues Final Technical Guidance on MA MPF Provider Directory Data

On February 18, CMS issued a notice and related materials announcing the release of the final "Technical Implementation Guide for Supplying Medicare Advantage (MA) Provider Directory Data for Use in Medicare Plan Finder (MPF)." CMS is issuing this final guidance to implement the requirements from the second final rule on changes to the MA and Part D programs for CY 2026, for MA plans to submit provider directory information to CMS for display on MPF.

The guide provides detailed technical specifications for Phase Two (Dual Option Solution) of implementation. For this phase, MA plans will have two options for supplying provider directory data to CMS for use in MPF: FHIR-based JSON API or machine-readable JSON files.

CMS intends to implement Phase Two for CY 2027.

CMS Releases Toolkit for Children's Behavioral Health Services and EPSDT

CMS released a Medicaid & Children's Health Insurance Program (CHIP) Toolkit for Children's Behavioral Health Services and the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Requirements. This toolkit includes strategies for developing a behavioral health care delivery system that can meet a range of children's needs, promoting early intervention for children's behavioral health conditions, improving children's access to behavioral health care through service coordination and integration, and increasing the workforce capacity for children's behavioral health services. The toolkit also includes recommendations on

how states can leverage their managed care contracts to encourage early intervention and delivery of behavioral health care that meets a range of needs. Read More

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HRSA Tries Again on 340B Rebate Model

The Health Resources and Services Administration (HRSA) has issued another request for information for its proposed 340B Rebate Model Pilot Program. The second public comment period comes after a federal court paused the launch of the program, ruling HRSA had not met its administrative requirements ahead of the January 1 rollout.

The agency is now seeking feedback about how to implement the program and the impact on covered entities, manufacturers, and other stakeholders across the drug supply chain. The deadline for comment is March 19.

Last week, the American Hospital Association and six national hospital and pharmacist organizations formally asked HRSA to extend the deadline for comments on the agency's new request for information (RFI) on the potential revival of a 340B rebate program. In a joint letter to HRSA Administrator Thomas Engels, the groups said the current 30-day comment period does not provide sufficient time for hospitals and other stakeholders to gather the detailed information the agency has requested.

America's Essential Hospitals, 340B Health, the American Society of Health-System Pharmacists, the Association of American Medical Colleges, the Catholic Health Association of the U.S., and the Children's Hospital Association joined the AHA on the letter. **The joint letter states that:**

- The RFI includes dozens of detailed questions requiring hospitals to compile significant financial, operational, and compliance data.
- Thirty days is not enough time for 340B hospitals to comprehensively gather the "facts, research, and evidence" HRSA has requested.
- Without granting an exception, HRSA will not have the opportunity to consider all aspects of the rebate issue.

The group requested that HRSA extend the comment deadline to April 20, 2026, to ensure stakeholders can provide meaningful and complete feedback.

Why this matters: The hospital community has warned of the fallout of the rebate model proposal and called on the federal government to consider alternatives. Given the potential magnitude of the changes that rebates would bring about, it is critical that hospitals have adequate time to assess the impact on their operations and provide HRSA with data-driven input.

Ensuring that HRSA fully understands the financial, operational, and patient-care harms that a rebate model would cause remains a top priority of hospitals.

State Issues

New York

Legislative

Budget Amendments

Late last week, Governor Hochul's Administration released 30-day amendments to the proposed Executive Budget.

Why this matters: The amendments to areas of the budget affecting health plans make two technical corrections:

- The first relates to the proposed changes to the "cooling off" period in contract negotiations between hospitals and health insurers. The amendments correct an omission in the original Article VII bill that made changes to one area of law but did not include other relevant sections of law.

- The second extends the APG rate mandate for behavioral health services in Medicaid managed care from March 31, 2027, to March 31, 2031.

- The amendments also amend the FY27 financial plan to reflect an additional $1.65B in MCO Tax revenue, resulting from recent federal action to extend the tax through the end of 2026. The funding would be spent over the next three years and would include $50 million for the Medicaid managed care Quality Incentive (QI) Program for FY28.

Next Steps: The Senate and Assembly are expected to release their own one-house proposals the week of March 9th. The New York Health Plan Association (HPA) is holding their annual budget lobby day, meeting with approximately two dozen members of the health and insurance committees, discussing the industry's budget priorities.

Among HPA's priority issues is supporting fully funding the Medicaid QI Program and codifying the program in statute. Last Friday, an op-ed from Assemblymember Jonathan Rivera ran in *The Buffalo News*, discussing several initiatives in Erie County that receive QI support and the importance of the program.

Legislative Update

Following a week off, lawmakers will return to Albany this week. Due to a major winter storm affecting southern New York state and New York City, both the Assembly and Senate canceled session on Monday. They are scheduled to reconvene on Tuesday and resume committee meetings. Bills of interest are on the following committee agendas. (Committee meeting times may change due to possible weather delays.)

Senate Standing Committee on Health
February 24 at noon

• S.354 (Rivera)/A.6334 (Woerner) – The proposal relates to the requirement enacted during the COVID-19 pandemic that telehealth visits be reimbursed at the same level as in person visits, making this arrangement permanent.

• S.707-A (May) – The legislation would require the Department of Health to post managed long-term care (MLTC) enrollment, financial and quality data on the DOH website in an interactive format.

• S.940 (Sanders)/A.7681 (Cook) – This would establish mandatory minimum stays for childbirth in Medicaid. New York law already mandates maternity stay requirements, which apply to Medicaid coverage.

• S.1912-A (Rivera)/A.7365 (Simone) – Mandates Medicaid coverage for medically tailored meals.

• S.6266 (Salazar)/A.2044 (Paulin) – The bill codifies the QI Program and requires budget funding to support it.

Senate Standing Committee on Women's Issues
February 25 at 9:30 a.m.

• S.520 (Persaud)/A.686 (Solages) – Ensures ovarian cancer survivors have the right to access screenings for health conditions.

• S.7731 (Webb)/A.7384 (Reyes) – Requires coverage of a hospitalized birthing parents interhospital transport to accompany their infant needing such transport.

State Issues

New York
Regulatory

Expanding Ambulatory Surgery Center Access for Cardiac Care
DOH's Public Health and Health Planning Council last week approved recommendations to expand the types of facilities that can perform some cardiac procedures to include ambulatory surgery centers.

Why this matters: The recommendations from PHHPC's Health Planning Committee call for beginning with low-risk procedures that are guided by an evaluation of safety and effectiveness, and to do the expansion in phases.

- During the process of evaluating this issue, there had been push back from larger hospital systems that argued it would have a significant negative financial impact.
- Those on the other side of the issue – including the New York Health Plan Association – pointed out that **the use of and expansion of ASCs could help lower health care costs as well as offer patients greater choice and convenience in accessing care.**

Next Steps: The next steps require DOH to draft regulations, which will then go out for public comment, with the final regulations subject to approval by PHHPC.

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State Issues

Pennsylvania

Legislative

Legislative Update

The Department of Insurance will go before the House Appropriations Committee to present and answer questions regarding their FY 2026-2027 budget request. The Department of Human Services will go before the Senate Appropriations Committee on Wednesday to do the same. At these hearings is where we expect to start to learn details on the administration's legislative plans surrounding Governor Shapiro's budgetary legislative initiatives, including False Claims, APCD, Co-Pay Accumulator and other legislation.

State Issues

West Virginia

Legislative

Legislative Update

Prior Authorization

- SB 822, which proposes extensive modification of prior authorization rules, has not been considered in the Senate and does not appear to be on the priority list for action in the Senate Health Committee but the matter is still open for action for another week before procedural deadlines in the legislative process will block the bill. There is no companion bill in the House and the House Health

Chairman has indicated his opposition to the Hospital Association proposal. 822 would apply to private health plans and to both PEIA and Medicaid.

PBM Regulation—Dispensing Fees

- **HB 5430** passed the House Friday proposing significant overhaul in the structure of the PEIA's pharmacy benefit program and the conduct of a study on the mandated level of dispensing fees paid by health plans and PBMs to pharmacies. The bill has minimal direct impacts but raises the prospect of significant increases in mandated dispensing fees in the future because of what is feared to be a study based on the flawed information on costs that is likely to be submitted by independent pharmacies, chain pharmacies and hospital pharmacies.

- **HB 5430** faces a potentially rock road to passage in the Senate because of concerns over how it may affect PEIA and how an increase in future dispensing fees will affect PEIA and Medicaid.

Emergency Medical Services Legislation

- **HB 5379** is now pending in the House Finance Committee after being previously approved by the Health Committee. This bill is very limited in scope with regard to its impacts on private health plans and their relationships with emergency medical services squads. The bill does require prompt payment of EMS claims and for private plans to pay non-network EMS companies directly.

- While the EMS Coalition has been aggressively pushing for legislation proposing to mandate private health plans pay EMS reimbursement at a level of 400% of Medicare rates the House has no appetite for such a proposal. However, the issue is still alive in the House in the form of SB 645, which is under the control of the Health Committee. .

Updates on Various Issues

- **Medicare Birthday Rule:** The House Finance Subcommittee on Banking & Insurance endorsed **HB 4869** on to the full Finance Committee last week. This bill proposes to create a new open enrollment period for Medicare Supplemental plan members. Health insurers objected to the original form of this bill, which is now set to be modified to only allow for an open enrollment/guaranteed issue period to open every other year during the birth month of the member. OIC representatives testified in support of the bill.

- **Dental Loss Ratio:** The initiative of the West Virginia Dental Association to seek passage of a bill requiring an 85% loss ratio for dental plans is not scheduled to be considered this year.

- **HB 4760, proposing to mandate health plans cover non-FDA approved food and nutrition supplements,** has been assigned to the House Finance Committee, where it is being met with significant opposition from key leaders on the committee. Highmark is strongly opposed to the creation of this unprecedented non-medical benefit mandate. The bill would also apply to PEIA and Medicaid.

- **HB 4089, proposing to mandate coverage of scalp cooling therapy for cancer patients,** has passed the House of Delegates but has received an unfavorable double committee reference in the Senate. Highmark has expressed no objections to this bill.

New Bills Introduced Last Week

- SB 946—Regulating hospital facilities fees.
- SB 954—Mandating health plan coverage for living organ donors.
- SB 956—Allowing for different forms of physician assistant collaborative agreements.
- SB 992—Conduct a study of unvaccinated and vaccinate pediatric patients.
- SB 994—Licensure of midwives.
- SB 995—Oversight of rural transformation grant funds.
- SB 1019—Mandate for coverage of cleft palate treatment.
- HB 5650—Allowing for the practice of neuropathic medicine.
- HB 5658—Allowing for inclusion of edible products in medical cannabis program.
- HB 5470—PhRMA cost-sharing coupon administration update.
- HB 5494—Creating an extension of local hotel taxes for the benefit of EMS.
- SB 906—Allowing for psilocybin to be prescribed.

Industry Trends

Policy / Market Trends

Medicaid Highlights in the CBO Budget and Economic Outlook: 2026 to 2036 Report

The Congressional Budget Office (CBO) released the Budget and Economic Outlook: 2026 to 2036 report to Congress.

Highlights related to Medicaid include:

- CBO lowered its projection of Medicaid outlays over the 2026–2035 period by $26 billion (or less than 1 percent) because of economic changes. In the current economic forecast, a larger share of the population is projected to be employed than in the previous forecast, which led to CBO decreasing projections of enrollment in Medicaid. This is reflective of the community engagement requirements passed in HR.1.

- Outlays for Medicaid were larger than expected in 2025, despite lower-than-expected enrollment. Costs per enrollee grew by 16 percent in 2025— significantly more than CBO had anticipated. In response, CBO increased Medicaid outlays over this period by 8 percent.

- That growth is attributable to a reported decrease in the average health status of Medicaid enrollees after the continuous eligibility policy put in place during the COVID-19 pandemic ended in April 2023. **CBO expects that payment rates for health plans that manage care for Medicaid enrollees will begin to rise in 2026 to reflect the decrease in the average health status of enrollees.**

Also of note, CBO now projects that H.R.1 will increase the national debt by $4.2 trillion through 2034 and $4.7 trillion through 2035 on a dynamic basis. Before the bill was enacted, CBO estimated it would raise the national debt by $1.9 trillion through 2034 and nearly $2.8 trillion through 2035.

MACPAC Releases February 2026 Edition of MACStats

The Medicaid and CHIP Payment and Access Commission (MACPAC) released the newest edition of the MACStats: Medicaid and CHIP Data Book. The data book includes updated data on national and state Medicaid and CHIP enrollment, spending, benefits, beneficiary health status, service use and access to care. Read More

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AHIP Amicus Briefs in *No Surprises Act* IDR Abuse Lawsuit & Arkansas Pharmacy Ownership Ban Litigation

- **IDR:** AHIP submitted an amicus brief in *Anthem v. HaloMD*, a lawsuit alleging that providers and their third-party biller are illegally abusing the *No Surprises Act*'s independent dispute resolution (IDR) process to extract higher out-of-network payments, including on otherwise ineligible claims. AHIP's brief provides the court with a broader view of the various issues impacting the IDR process, including the significant volume of ineligible claims being submitted, the high costs and other impacts associated with abuse of the IDR process, and other related problems.

  The brief continues AHIP's advocacy on this issue and leverages the results of a recent survey conducted by AHIP and the Blue Cross Blue Shield Association illustrating how persistent misuse and inefficiencies in the IDR process are increasing premiums and driving wasteful health care spending.

- **Arkansas Pharmacy Ownership Ban:** AHIP submitted an amicus brief in the U.S. Court of Appeals for the 8th Circuit in *Express Scripts v. Richmond*, a lawsuit challenging an Arkansas law banning PBM-owned pharmacies. AHIP's brief provides the court with the impact of the law on health plans and those who rely upon health plans for high quality, affordable, and accessible pharmacy services. It discusses the need for more pharmacies, not fewer, to avoid pharmacy deserts and to provide the competition necessary for affordability. The brief explains banning PBM-affiliated pharmacies in Arkansas will threaten access to affordable healthcare, both in Arkansas and beyond.

  The brief follows on industry legislative and regulatory advocacy related to these types of state laws and is consistent with AHIP's broader argument that health care affordability, quality, and access depend on competition in underlying healthcare markets.

DOGE Releases Open-Sourced Medicaid Claims Dataset

The Department of Government Efficiency's (DOGE) HHS team announced the release of what it describes as the largest Medicaid claims dataset in department history, publishing aggregated, provider-level claims data by billing code on HHS's open data portal. DOGE officials said the dataset could serve as an anti-fraud tool. The release follows earlier outreach from HHS leadership asking governors to share state Medicaid claims data for federal analysis of long-term outcomes and potential overutilization of drugs such as GLP-1 weight-loss

Interested in reviewing a copy of a bill(s)? Access the following web sites:

Delaware State Legislation: **http://legis.delaware.gov/.**
New York Legislation: **https://nyassembly.gov/leg/**
Pennsylvania Legislation: **www.legis.state.pa.us.**
West Virginia Legislation: **http://www.legis.state.wv.us/**
For copies of congressional bills, access the Thomas website – **http://thomas.loc.gov/.**

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