Highmark's Weekly Capitol Hill Report

Issues for the week ending August 14, 2026

Federal Issues

Regulatory

Appeals Court Vacates Qualifying Payment Amount Methodology Under No Surprises Act

A federal appeals court struck down key parts of the formula used to calculate the Qualifying Payment Amount (QPA), a key benchmark in the No Surprises Act's (NSA) independent dispute resolution (IDR) process.

Background: The QPA acts as a baseline for determining individual cost sharing for services covered by balance-billing protections in the NSA, such as when an out-of-network provider is used in an in-network facility or for emergency services, and is central to the first phase of dispute resolution.

Why this matters: The U.S. Court of Appeals for the Fifth Circuit opinion largely affirms a previous federal district court ruling that portions of the government's QPA methodology conflict with the NSA.

What this means:

The decision holds that current QPA methodology:

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- Unlawfully included “ghost rates”, those established for services that providers do not actually offer, in QPA calculations.

- Unlawfully excluded bonus, incentive and other payment adjustments tied to a service from QPA calculations.

- One-off or single-case agreements, including many air ambulance arrangements, can still be excluded from QPA calculations

- Absent further legal action, federal agencies will need to issue new regulations with a revised QPA methodology.

While these new regulations are being developed, existing QPAs can continue to be used in the interim.

The big picture: By removing ghost rates and adding bonus payments to the QPA methodology, QPA benchmarks are likely to be pushed higher and raise arbitration outcomes for providers – furthering ongoing affordability concerns with the NSA’s IDR process.

What’s next: We will continue to monitor for new federal guidance and regulations implementing changes to the QPA methodology.

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Regulatory

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Administration Issues Executive Order on Childhood Vaccine Policy

The administration issued an executive order aiming to reduce the number of vaccines routinely recommended for all children and change how some vaccines are administered.

Why this matters: The executive order's changes to the childhood and adolescent vaccine schedule, if recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the CDC, could result in lower vaccine utilization by reducing the number of recommended routine childhood vaccines and requiring more medical visits to receive vaccines.

The big picture: While the proposal could impact vaccine utilization, health plan coverage requirements remain unchanged for now.

What's happening: The administration's executive order directed federal agencies to update childhood vaccine recommendations by:

- Moving some vaccines from routine recommendations to recommendations for specific populations or shared clinical decision-making. For example:
    - Requesting hepatitis A, hepatitis B, meningococcal B, meningococcal ACWY, respiratory syncytial virus monoclonal antibodies and dengue vaccines be recommended only for certain high-risk groups or populations.
    - Requesting hepatitis A, hepatitis B, rotavirus, meningococcal disease, influenza and COVID-19 vaccines be recommended based on shared clinical decision-making.
- Separating certain combination vaccines into individual doses when available.
- Encouraging childhood vaccines to be administered during separate medical visits to the maximum extent feasible.

Zoom out: The order follows an earlier directive requiring a review of the childhood and adolescent vaccine schedule.

What this means for plans: No vaccines are being removed from the schedule entirely. As a result:

- Coverage requirements under ACA-compliant plans, Medicaid, CHIP and the Vaccines for Children program remain unchanged.
- Vaccines currently recommended for children must continue to be covered without cost sharing.
- Vaccines recommended through shared clinical decision-making generally must also be covered without cost sharing when recommended by a clinician.

What's next: The administration directed the HHS Task Force on Safer Childhood Vaccines to submit recommendations within 90 days on steps to change the vaccine schedule, separate the MMR vaccine into individual components and launch other vaccine-related initiatives. Any vaccine schedule changes would still require ACIP and CDC action before taking effect.

Departments Release FAQs Outlining Implementation Timeline for IDR Operations Rule

On Aug. 7, 2026, the Departments of Labor, Health and Human Services (HHS), and the Treasury (Departments), along with the Office of Personnel Management (OPM), released the Federal Independent Dispute Resolution (IDR) Operations Final Rules Implementation Timeline Guide for Certified IDR Entities and Disputing Parties. This guidance provides details regarding the applicability dates of certain provisions associated with final rule.

Key highlights include the following:

- The guidance confirms that many of the Rule's provisions are contingent on future IDR Gateway functionalities, and those provisions generally will not take effect until 90 days after those functionalities are added.
- The Departments laid out the planned order in which IDR Gateway functionalities will be rolled out. While the Gateway will launch in late 2026, the order of functionalities to be implemented beginning in Spring 2027 is (1) IDR Registry, (2) suspension of resubmission of incorrectly batched/bundled disputes, (3) open negotiation, (4) initiation, (5) certified IDR entity selection, (6) withdrawals, and (7) extensions.
- The Departments confirmed that several provisions not tied to IDR Gateway functionality were applicable starting Aug. 3, 2026. This includes the new definition of a bundled payment arrangement, QPA disclosure requirements and new IDR entity fee policies.
- Batching provisions, including the revised batching definition and the treatment of batched/bundled disputes, will apply for disputes with open negotiation periods beginning on or after Nov. 1, 2026.

The FAQs also include a chart of applicability dates of key provisions from the rule and additional details on implementation of the rule.

AHIP Submits Comments on Community Engagement Interim Final Rule

On July 31, AHIP submitted comments to CMS on the Medicaid Community Engagement interim final rule (IFC).

Recommendations Include:

- Removing the "significant impairment" provision of the medically frail designation.
- Providing more clarity on ways that states can work with MCOs to implement the new requirements.
- Utilizing existing tools and claims data to assist in accurate eligibility determinations and prevent unintended coverage losses.
- Ensuring that CMS works with key stakeholders to implement a comprehensive and coordinated educational campaign.

Key Excerpt: "As CMS implements the Medicaid community engagement requirements, we are supportive of policies and implementation efforts that limit burdens and uncertainty for states, beneficiaries and other stakeholders; minimize erroneous disenrollments; and make potential technology solutions as scalable and cost-effective as possible. However, we respectfully submit that various policies in the IFC do not achieve these objectives or meet the goals that CMS described in the IFC (including limiting costs and ensuring auditable standards)."

CMS Locks in 2027 Hospital Rules, Boosts Electronic Prior Authorization

CMS recently finalized a rule that sets 2027 original Medicare payment rates and quality reporting standards for inpatient and long-term hospital services starting Jan. 1, 2027.

Why this matters: Several of the final policies touch on issues BCBSA raised in comments, with downstream effects for Plans with Medicare Advantage (MA) business, including provisions that impact electronic prior authorization (ePA), quality reporting and maternal care.

The details: Of interest to Plans, CMS finalized provisions related to:

- **ePA:** In a win for one of BCBSA's top priorities, CMS finalized several policies to advance ePA and speed up care approvals. The ePA measure, which will be an optional bonus measure in 2027, will be required starting in 2028.
- **Hospital Quality Reporting:** BCBSA also supported one of the three new hospital quality measures CMS finalized — an advance care planning measure that takes effect in 2030.
- CMS also is expanding several measures to count MA patients, not just original Medicare patients; and starting in 2028, hospitals must report which maternal health improvement network they participate in.

Our take: We're pleased the CMS continues to advance ePA — one of our core priorities — and will continue engaging with the administration on the priorities that weren't finalized this round.

Other Key Highlights

- **Payment Updates:** The finalized increase in operating payment rates for general acute care hospitals is **2.3%**. Overall, for FY 2027, CMS expects the proposed changes in payment rates — in addition to other changes — will increase hospital payments by approximately $2.1 billion.

- **Expansion of the Comprehensive Care for Joint Replacement (CJR) Model:** CMS finalized its proposal to create the CJR Expanded (CJR-X) Model, a nationwide, mandatory model for lower extremity joint replacement (LEJR) procedures. Participating hospitals would be held accountable for spending and quality of care during an inpatient stay or hospital outpatient procedure and for the 90 days following hospital discharge.

- **Adoption of Standards for Patient, Provider and Payer APIs:** As a part of IPPS, CMS finalized its proposal to adopt a set of health information technology standards for patient, provider and payer APIs as initially proposed in the 2026 Interoperability Standards and Prior Authorization for Drugs Proposed Rule.

CMS Issues Updated Guidance Following *City of Columbus v. Kennedy* Stay

CMS issued several updated documents related to the U.S. District Court for the District of Maryland's order in *City of Columbus v. Kennedy, No. 1:26-cv-02215*. The court stayed several provisions of the 2027 Notice of Benefit and Payment Parameters while litigation remains pending. The updated documents include:

- Updated Revised PY2027 QHP Data Submission and Certification Timeline Bulletin
- Guidance on Standardized Plan Options and Non-Standardized Plan Option Limits and Exceptions

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Transparency in Coverage Final Rule Under OMB Review

The Transparency in Coverage (TiC) final rule (CMS-9882) has advanced to review at the Office of Management and Budget (OMB). This review, conducted by OMB's Office of Information and Regulatory Affairs (OIRA), is generally the last step before a final rule is published.

Why this matters: The rule would finalize the proposed rule published on December 23, 2025, which would restructure health plan machine-readable files and add four new contextual files. BCBSA submitted comments on the proposed rule earlier this year. Our comments supported the administration's goal of streamlining the data and offered alternatives where the proposals raised operational and implementation concerns.

OIRA received the rule on July 27 and has up to 90 days to complete its review, although that period can be extended. We will continue to keep Plans updated as the rule advances and will share a regulatory analysis following the rule's publication.

CMS Releases Toolkit to Strengthen State Oversight of Applied Behavior Analysis

On August 4, CMS released the State Medicaid and CHIP Applied Behavior Analysis (ABA) Toolkit, a comprehensive resource to help state Medicaid and CHIP agencies address growing concerns about increasing expenditures, inconsistent clinical practices, and fraud schemes targeting autism services.

Why this matters: CMS noted that between 2021 and 2025, ABA spending in Medicaid and CHIP increased 421%, far outpacing the 67% growth in the number of children with an Autism Spectrum Disorder (ASD) diagnosis receiving any Medicaid or CHIP service, and highlighted $198.4 million in improper Medicaid billing for ASD-related services identified across several states. Beyond recommendations for states, the toolkit also highlights examples of state oversight approaches.

CMS noted it is not endorsing or requiring any particular treatment for ASD, nor establishing new federal requirements or reducing Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) obligations.

CMS Finalizes Rule Restricting Payment for Gender-Affirming Care for Youth in Medicaid and CHIP

On August 11, CMS published a final rule (CMS-2451) prohibiting the use of federal financial participation for "sex-rejecting procedures" for Medicaid beneficiaries under age 18 and separate CHIP enrollees under age 19. This includes puberty suppression, cross-sex hormone therapy, and surgical procedures.

Why this matters: The rule, scheduled to take effect October 13, 2026, applies to approximately 17 state Medicaid programs that currently cover one or more of these services and requires state Medicaid and CHIP plans to bar payment for covered procedures. Federal matching funds will be available for a tapering-off period of up to six months from the effective date for children currently on hormone therapy. The rule does not affect coverage of mental health services, and CMS noted it does not reduce states' EPSDT obligations for other services. CMS released this press release highlighting the publication of the final rule.

CMS Releases Implementation Tool for Noncitizen Medicaid Eligibility Changes

On Aug. 4, CMS released a state implementation tool for Section 71109 of the Working Families Tax Cut Legislation, which limits federal Medicaid and CHIP funding for full benefits to certain noncitizen populations beginning Oct. 1, 2026. Federal financial participation will generally remain available for U.S. citizens and nationals, lawful permanent residents, Cuban/Haitian entrants, and migrants covered under the Compacts of Free Association, with exceptions for emergency Medicaid and certain lawfully residing children and pregnant women.

Why this matters: States must redetermine the immigration status of potentially affected beneficiaries, update applications and eligibility systems, issue appropriate notices, and modify financial and enrollment reporting before the October 1 deadline. Beneficiaries whose status cannot immediately be verified may receive a 90-day opportunity period while verification continues, and states must assess eligibility for other coverage options before reducing or terminating benefits; states that cannot comply by October 1 must stop claiming federal funding for potentially affected beneficiaries until they complete the necessary changes.

Centers for Medicare & Medicaid Services July 2026 Data Products Recap

The Centers for Medicare & Medicaid Services (CMS) is highlighting several data products the agency released during the month of July:

- **Medicare Current Beneficiary Survey (MCBS) – Annual Updates**
  The 2024 Medicare Current Beneficiary Survey (MCBS) Survey File Limited Data Set provides data on topics such as social determinants of health, economic outcomes, health insurance coverage, and barriers to accessing care and is augmented with administrative enrollment and claims data. The 2025 Medicare Current Beneficiary Survey (MCBS) Bibliography provides a listing of peer reviewed journal articles and government publications that utilized MCBS data in their analyses.
- **Medicare Durable Medical Equipment, Devices & Supplies Public Use Files – Annual Update**
  The Medicare Durable Medical Equipment, Devices & Supplies datasets summarize utilization, payments, and submitted charges for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) services provided to Original Medicare (Fee-For-Service) beneficiaries. Datasets are aggregated by referring/ordering physicians and other healthcare professionals, DMEPOS suppliers, type of service, and geography. The latest data available are for calendar year 2024.

- **Medicare Advantage Geographic Variation Public Use File – Annual Update**
  The Medicare Advantage Geographic Variation PUF (MA GV PUF) includes utilization data for services provided to Medicare Advantage (MA) beneficiaries in inpatient hospitals, skilled nursing facilities, outpatient, durable medical equipment and professional services by state. The dataset also includes demographic information for the MA population. The file now includes data for calendar year 2023.
- **Medicare Drug Spending Data – Quarterly Update**
  The Medicare Quarterly Part B and Part D Drug Spending Datasets provide more timely information on use and spending for drugs prescribed to Medicare beneficiaries. This release includes Quarters 1-4 of 2025 and Quarter 1 of 2026. These preliminary datasets will be updated each quarter and may change with each new release due to claims lag. Once an entire year of data is available with a sufficient run-out period, that data will move out of the preliminary quarterly dataset and into the final, annual version of the Medicare Part B and Part D Drug Spending datasets.
- **Medicare Enrollment – Monthly Update**
  The Medicare Monthly Enrollment Public Use File and Medicare Enrollment Dashboard present counts of Medicare beneficiaries with hospital/medical coverage and prescription drug coverage by geographic area and now include enrollee counts for April 2026.

State Issues

Pennsylvania

Regulatory

State Releases Behavioral Health Action Plan

The Shapiro administration released its report detailing action steps to improve Pennsylvania's behavioral health care system.

The report, a culmination of three years of fact finding, dialogue, and brainstorming by the Behavioral Health Council and Advisory Committee, establishes six goals to address the commonwealth's behavioral health challenges and to build a system where every Pennsylvanian can access timely, affordable, and high-quality mental health and substance use disorder care.

The six goals in the **Behavioral Health Council Action Plan** include:

- Develop an integrated care system
- Expand access to services
- Strengthen the workforce and provider support
- Enhance accountability and transparency
- Advance equity in behavioral health
- Improve criminal justice and behavioral health integration

The advisory committee includes 60 government, health care, and community organization leaders, as well as individuals and families.

The report outlines 40 recommendations with high-level action steps and performance measures to advance the overall goals. It includes recommendations related to strengthening the crisis services system and establishing behavioral health walk-in or drop-off centers to reduce emergency department utilization and criminal justice involvement and developing specialized facilities or units to serve geriatric individuals with complex behavioral health and medical needs.

Why this matters: Created by Executive Order, the Council's work involves examining new care delivery models, assessing workforce needs and funding sources, improving regulations and payment systems, and integrating mental health and SUD care with primary care while addressing social needs gaps. Council members analyzed successful local models and discussed how to replicate effective partnerships across the Commonwealth.

Implementation will require ongoing collaboration across state agencies, counties, providers, payers (including insurers), communities, and people with behavioral health disorders. Broader deliberative stakeholder input is warranted before final implementation to avoid unintended consequences that could create additional barriers to the delivery of care.

Industry Trends

Policy / Market Trends

New Peer-Reviewed Study Adds to Evidence Rebutting MedPAC Claims About MA

AHIP is highlighting a new peer-reviewed study published in *Health Affairs Scholar*, demonstrating MedPAC significantly overestimates favorable selection within Medicare Advantage (MA).

Key Context: The report adds to a growing body of evidence that raises serious questions and concerns about the data, methodology and conclusions of MedPAC's comparisons of MA and FFS.

By The Numbers: The new peer-reviewed study **finds significantly lower rates of favorable selection within MA** than MedPAC estimates.

- The study estimated favorable selection at **4.9%–5.8%** in 2020–2022**.**
- That is **32%–40%** lower than the authors' replication of MedPAC's extrapolation method estimate (8.2%–8.8%), and **well below MedPAC's published estimates** of 10%-15%.

Why this matters: MedPAC's figures often underpin policy recommendations affecting more than 35 million MA seniors and people living with disabilities. If outside researchers can't reproduce those estimates from MedPAC's own methodology description, the figures are not a sound basis for policy determinations.

Dive Deeper: Read AHIP's blog highlighting the *Health Affairs Scholar* findings here.

Politico Highlights Costly Provider-Driven Abuse of IDR System

Politico published new report underscoring how growing provider-driven abuse of the *No Surprises Act's* flawed IDR system is costing Americans billions of dollars.

Highlights Include:

- Egregious examples of IDR abuse with arbitrators awarding out-of-network providers and IDR middlemen vastly more than their services normally cost.
- How the volume of IDR disputes – and associated costs – continue to rise.
- "Doctors are gaming the system" with massive IDR payouts that add waste to the healthcare system.
- Nearly 40% of disputes in 2024 were ineligible and should have been disqualified, yet arbitrators issued payment determinations on most of them anyway.
- Efforts to oppose legislation that would expand the loophole to allow for continued abuse and misuse of the *No Surprises Act* that was designed to protect patients.

What AHIP Is Saying: "Policy action is needed to put an end to this gold rush," AHIP spokesman Chris Bond told *Politico*.

A Growing Chorus: The *Politico* piece is the latest in a series of recent news articles that highlighted the broken IDR system. Recent investigative reports – including by *The Wall Street Journal*, *The New York Times* and *STAT* – have pulled back the curtain on growing provider-driven IDR abuse. *The Wall Street Journal* and *Washington Examiner* editorial boards have also called for policy action.

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 https://www.congress.gov/