

Federal Issues

Legislative

House Clears Senate-passed Budget Resolution

Members of Congress left Washington for a district work period this week, after the House passed [S. Con. Res. 33](#), the Senate's FY26 budget resolution, by a vote of [215-211-1](#). Passage clears the way for both chambers to begin work on reconciliation instructions. Before the break, Congress passed Homeland Security funding, effectively ending the partial government shutdown that has been in place since February. The coming reconciliation bill is expected to fund Immigration Customs Enforcement (ICE) and Custom Border Patrol (CBP) without support from Democrats, who are seeking broader reforms.

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Senate Democrats Unveil Healthcare Vision

On April 28, Senate Minority Leader Chuck Schumer (D-NY) [released an outline](#) of the Democratic agenda to lower health care costs, expand access to reliable care for Americans across the country, and make it easier for patients and families to get the care they need. The framework contains three buckets:

- **Lower costs:** including premiums, deductibles and out of pocket costs and lowering the cost of prescription drugs, doctors' visits and procedures
- **Reliable care:** by addressing access issues, strengthening the workforce and allowing patients and providers – not politicians or corporations – to make care decisions
- **Simpler care:** by making it easier for Americans to choose insurance plans, reduce care delays and denials, and make it easier for patients to get support when needed

Ways and Means Committee Grills Hospital CEOs

On April 28, the House Ways and Means Committee held a [hearing](#) with hospital CEOs as part of its ongoing healthcare affordability workstream. Previous hearings have focused on drug manufacturers and health insurers.

Chairman Jason Smith (R-MO) argued that hospital consolidation and corporate practices are major drivers of rising health care costs, harming patients without improving care. While acknowledging the essential role of hospitals and clinicians, he criticized large health systems for prioritizing profits over patients, exploiting market power through mergers, charging exorbitant and often arbitrary prices and using legal loopholes and federal subsidies to increase revenues. He highlighted concerns related to site of service payment differentials, tax exempt status, rural residency slots, and the 340B program, concluding these practices fuel consolidation and higher premiums. He stated hospital prices are the largest contributor to premium growth and vowed continued oversight and reform to hold hospitals accountable.

Ranking Member Richard Neal (D-MA) countered that Republicans are holding repeated hearings to deflect responsibility for rising costs, while Democrats have delivered tangible savings by taking on health care corporations. He cited Medicare drug price negotiation, insulin and out-of-pocket caps, expanded benefits, record Marketplace enrollment, and income-based premium limits. Neal criticized Republicans for allowing the ACA premium tax credits to expire, arguing that Republican proposals shift costs onto patients, and called for reversal of the GOP Medicaid reforms and extension of the premium tax credits.

The witnesses: Hospital CEOs broadly agreed that cost pressures stem from labor, supply, pharmaceutical, administrative, and regulatory factors, as well as coverage gaps, prior authorization requirements and payment disputes. Executives from HCA, CommonSpirit, New York Presbyterian, and ECU Health called for greater efficiency, transparency, fair competition, adequate Medicare and Medicaid reimbursement (especially for Medicare Advantage (MA)), and regulatory reform, while warning against one size fits all policies, particularly for rural hospitals. Common Spirit highlighted unpaid MA claims and voiced support for several of the members' MA bills to address prompt pay and other issues. Protect Our Care argued that affordability is fundamentally a coverage issue and warned that the Medicaid cuts would worsen access and accelerate hospital closures nationwide.

Questions from the PA delegation:

Representative Brian Fitzpatrick (R-1) focused on physician workforce shortages and called for support for legislation that would provide additional Medicare funding to add 14,000 residency slots focused on rural and underserved areas, as well as hospitals training over their resident caps.

- **Issues raised:** Price transparency, consolidation, workforce shortages.
- **Quotable:** "The country is facing significant physician shortages that is impacting access to care for millions of Americans," he said.

Representative Mike Kelly (R-16) discussed challenges for rural hospitals and the costs of care in small markets. He asked the panel for solutions to address costs, particularly in rural areas. He described the "math problem" of caring for communities with low patient volumes.

- **Issues raised:** Rural health care, cost of care.
- **Quotable:** "You can't have the people in the lobby looking for help when you don't have a doctor or nurse to take care of them," Kelly said.

Representative Dwight Evans (D-3) cited concerns about rising premiums after the Affordable Care Act and hospital insurance costs for employees.

- **Issues raised:** Access to health insurance, the loss of Affordable Care enhanced premium tax credits, challenges around health care, food, and housing.
- **Quotable:** "How does a growing number of uninsured and under-insured patients impact our strained health care system?" he asked.

Representative Lloyd Smucker (R-11) cited a Congressional Budget Office report on the impact of H.R. 1 on coverage, noting a large share of coverage losses due to people being unable or unwilling to fulfill newly required work requirements or income verification.

- **Issues raised:** Cost of Affordable Care Act premiums, Medicaid work requirements, executive pay, and nonprofit status.
- **Quotable:** “We all want to ensure that everyone has access to the health care that they deserve and at a price they can afford,” he said.

Other issues raised:

- Representative Jodey Arrington (R-TX) pressed CEOs on site neutral payments.
- Representative Blake Moore (R-UT) asked whether their smaller peer hospitals use insurance contracts to limit patient choice and raised concerns that hospitals are investing heavily in AI tools that increase coding intensity and reimbursement rather than improving care.
- Rep. John Larsen (D-CT) raised the Department of Justice’s investigation into New York Presbyterian’s alleged anti-competitive practices.
- Representative Suzanne Delbene (D-WA) raised concerns about the WiSER model and the use of AI for prior authorization denials.

Paragon Event Features Dr. Oz

On April 28, CMS Administrator Dr. Mehmet Oz, Senator Ron Johnson (R-WI) and Representative John Joyce, M.D. (R-PA) participated in a Paragon Health Institute [event](#) focused on combating health care fraud, waste and abuse.

Dr. Oz largely focused his remarks on hospice and Medicaid fraud, with a notable exchange on fraud in the individual marketplace. He argued that the ACA was meant as a bridge between employer sponsored insurance and Medicaid or Medicare. However, the emphasis on maximizing enrollment, combined with the expansion of \$0 premium plans, created incentives for fraud, including individuals being enrolled without their knowledge. Dr. Oz pointed to more than one-third of enrollees having no claims history as evidence of fraud and touted the administration’s program integrity efforts to address these issues.

On Medicaid, Dr. Oz asserted that poorly written regulations have enabled both legal and illegal fraud. He praised CMS efforts in Minnesota and described H.R. 1, the One Big Beautiful Bill, as essential to “saving” Medicaid by curbing abuses such as provider taxes, state directed payments, and fraudulent behavior by providers and brokers.

He urged Congress to codify the administration’s Most Favored Nation Rx deals, praised collaboration with insurers on prior authorization, and highlighted efforts to advance interoperability with the tech sector. Dr. Oz concluded by emphasizing the potential of artificial intelligence (AI) to curb waste, fraud and abuse, and urged Congress to create a safe regulatory environment for AI innovation.

Following the fireside chat, the Paragon Health Institute moderated a panel with Senate Homeland Security Permanent Subcommittee on Investigations Chairman Senator Ron Johnson (R-WI) and House Energy Subcommittee on Oversight and Investigations Chairman Representative John Joyce (R-PA-13). Both agreed that Medicaid fraud is a significant cost driver and argued that H.R. 1 would eliminate much of the abuse. Senator Johnson blamed the third-party payer system for removing consumer oversight because patients never look to see if what is billed is correct. He echoed Dr. Oz's criticisms of \$0 premiums and blamed brokers and insurance companies for exploiting subsidies.

Federal Issues

Regulatory

DOE Issues Final Rule on Professional Student Classification

The Department of Education April 30 released a [final rule](#) that defines the terms “professional student” and “graduate student” to determine federal student loan amounts based on the type of program in which a student is enrolled.

The rule defines “professional students” as individuals enrolled in one of 11 designated professional degree programs: pharmacy, dentistry, veterinary medicine, chiropractic, law, medicine, optometry, osteopathic medicine, podiatry, theology and clinical psychology. Students in those programs would qualify for up to \$50,000 in federal loans per year, with a \$200,000 aggregate limit, while graduate students would be eligible for up to \$20,500 in federal student loans per year, with a \$100,000 aggregate limit. The changes are set to take effect July 1.

Why this matters: Hospitals are disappointed by the Department of Education’s decision to exclude highly skilled health professionals such as advanced practice nurses, physician assistants, and physical therapists from their final definition of a professional student. The definition fails to account for the significant education and training required to enter these professions and could deter prospective students from pursuing health care careers.

Trump Administration Announces 17th Most-Favored-Nation Drug Agreement

The Trump administration announced the 17th most-favored-nation (MFN) pharmaceutical pricing agreement on April 23, this time with Regeneron. Under the [agreement](#), Regeneron will reduce the price of its cholesterol medicine Praluent from \$537 to \$225 for patients purchasing through TrumpRx.gov, and all future Regeneron medicines will be subject to MFN pricing for U.S. patients. The announcement also included FDA approval of Regeneron's new gene therapy Otarmeni — a treatment for a rare form of genetic deafness — approved on an expedited timeline through the FDA Commissioner's National Priority Voucher Program. This treatment will be provided to U.S. patients at no cost as part of the agreement.

The 17 MFN agreements now in place are designed to align U.S. drug prices with the lowest prices paid in comparable developed nations. For Medicare Part D plan sponsors, the practical intersection of MFN pricing with existing Maximum Fair Prices under the IRA drug negotiation program — and with the GUARD model for Part D drugs — will require continued monitoring as CMS operationalizes these arrangements through rulemaking and program guidance.

CMS Opens Comment Period on 2028 Medicaid Home and Community-Based Services Quality Measure Set

The Centers for Medicare & Medicaid Services (CMS) is seeking comments and feedback on the proposed [2028 Medicaid Home and Community-Based Services \(HCBS\) Quality Measure Set](#).

Per 42 CFR 441.311 as codified by the final rule, “Ensuring Access to Medicaid Services” (89 FR 40542), CMS requires states to report on the HCBS Quality Measure Set every other year beginning July 9, 2028. The proposed measures are in [Table 4](#) of the Notice of Proposed Rulemaking.

CMS is requesting comments on:

- The proposed mandatory and voluntary measures;
- How states collect, calculate, and report data on the proposed measures;
- The proposed measures for which states are required to report stratified data and the proposed stratification factors for each of those measures, including rural/urban status;
- The proposed populations that the measures apply to; and
- The proposed reporting schedule.

Comments are due May 28, 2026.

CMS Updates

- **CMS Provides Updates on Unpaid 2022 and 2023 Risk Adjustment Charges by Bright Health Group and Friday Health Plans:** On April 27, 2026, CMS issued a [memo](#) that provides updates on the collection efforts undertaken for unpaid 2022 benefit year risk adjustment charges by Bright Health Group and unpaid 2022 and 2023 benefit year risk adjustment charges by Friday Health Plans. The memo includes details of the interest waiver decision for Bright Health Group, what Bright has paid towards their charge balances, and updates the collection amount for Friday Health Plans.
- **Plan Year 2027 QHP Issuer Agreement:** CMS plans to roll out a finalized Qualified Health Plan (QHP) Issuer Agreement for Plan Year 2027 soon. In the attached draft versions of the Agreement that CMS has circulated, the only changes from Plan Year (PY) 2026 are updated dates in Section IV ([Effective Date](#); [Term](#); [Renewal](#)).
All issuers participating in the Federally-facilitated Exchange (including state-based Exchanges on the federal platform) for the 2027 plan year will need to sign the applicable finalized Agreement before submitting any transactions or connecting to the Exchange.
- **CMS Issues Updated Final Technical Guidance and Supplemental Resources on Medicare Advantage Medicare Plan Finder (MPF) Provider Directory Data:** On May 1, CMS issued a memorandum and related materials announcing the release of the updated “Technical Implementation Guide for Supplying Medicare Advantage (MA) Provider Directory Data for Use in Medicare Plan Finder (MPF).” CMS is issuing this updated 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. In addition to the updated technical guide, CMS also provides several supplemental resources including quick reference

guides, a frequently asked questions document, and a flyer for the annual CMS & HL7 FHIR Connectathon.

In the cover memorandum, CMS notes that “the original technical guide indicated that CMS would dynamically query each FHIR endpoint to extract the MA provider directory data in bulk.” However, “CMS has shifted course on how to retrieve these data when supplied in the FHIR-based JSON format” due to “the substantial expected record count, the number of requests that would be necessary to execute these dynamic extractions, the potential impact on plan systems, and cost concerns” related to using dynamic queries. CMS provides details on an interim solution for CY 2027 in the technical guidance “that anticipates the capabilities that will become available through the FHIR bulk publish operation.”

State Issues

New York

Legislative

Legislative Update

- **Primary Care:** The Primary Care Investment Act is on the Senate Health agenda this week – meeting Tuesday, at noon. The bill (S.1634-B (Rivera)/A.1915-A (Paulin)) would require all health insurers to report the percentage of overall annual health care spending on primary care services and mandate that at least 12.5% of all total annual expenditures are directed to primary care services. The Assembly Health Committee advanced the bill last week.
- **Mandated Benefits:** Also of interest to health plans, last week Senate Insurance Committee Chair Bailey introduced a bill to require the Superintendent of the Department of Financial Services to conduct a review of mandated benefits and their impact on insurance premiums and to conduct a cost analysis of legislation mandating new insurance benefits (S.10080). Assembly Insurance Committee Chair Weprin has a similar bill (A.8364). The New York Health Plan Association strongly supports the effort for New York to establish a mandate review process and is working with the Assembly sponsor on updates that will make the two bills align.

State Issues

Pennsylvania

Legislative

Legislative Update

Both the House and the Senate return this week for a three day voting session.

The House Communications and Technology Committee will convene for a voting meeting at 9am on Tuesday to consider House Bill 1925 by Representative Venkat. This legislation would establish new mandates and reporting requirements on the use of Artificial Intelligence on both insurers and providers.

Highmark has provided comments expressing our concerns with the bill and a proposed amendment to the legislation.

On Wednesday the House Insurance Committee will convene to vote on several pieces of legislation modernizing language in preexisting Acts. These bills will change references to “Human Services” from “Public Welfare”.

Once the chambers adjourn on Wednesday they will be on their Spring Break and will not return until Monday, June 1 for the budget session.

Pennsylvania House Passes Midwifery Bill

Last week, the Pennsylvania House passed legislation that establishes a pathway to licensure for Certified Midwives (CM) in Pennsylvania.

[Senate Bill 507](#) serves as a key step in expanding access to high-quality, maternal health care through pregnancy, labor and delivery, through the postpartum period, and improving maternal health outcomes. Specifically, the legislation creates a path to licensure for certified midwives and allows midwives to prescribe certain medications for opioid use disorder.

Pennsylvania hospitals face shortages for advanced practice providers, including certified nurse midwives (19%) and other perinatal professionals. This number is higher in rural communities.

The legislation heads to the governor’s desk for his signature.

Why this matters: Establishing a licensure pathway strengthens the perinatal workforce and expands access to care for pregnant and postpartum women. Additionally, expanding treatment for opioid use disorder will help reduce risk of relapse, overdose, and death among pregnant and postpartum women.

Regulatory

Patient Safety Authority Releases 2026 Final Updated Guidance for Acute Health Care Facilities

The Pennsylvania Patient Safety Authority (PSA) has issued updated guidance in the April 25 *Pennsylvania Bulletin* for acute health care facilities. This updated guidance provides clarity around specific occurrences of event reporting for serious events, incidents, or infrastructure failures. It updates reporting requirements under the Medical Care Availability and Reduction of Error (MCARE) Act for acute health care facilities.

This updated guidance includes:

- New Guidance for Injury Definition and Investigation and Documentation
- Clarification on previous guidance for:
 - Diversion and discrepancy reporting

- Additional healthcare services
- Unanticipated events
- Amendments to previous guidance, including:
 - Transfers and Cancellations from Ambulatory Surgery Facilities
 - Other (restraints and seclusion)

This guidance was developed by a multi-disciplinary work group including representatives from the Patient Safety Authority, the Department of Health, The Hospital and HealthSystem Association of Pennsylvania and health care facilities in this Commonwealth, with expertise in medicine, nursing, administration, facility operations, regulation, patient safety and health care quality.

Why this matters: This guidance aims to clarify standards and expectations for MCARE Act reporting so the Authority, the Department and facility staff share a consistent understanding. Topics were selected based on frequently asked questions and data inconsistencies observed by the Authority and the Department.

Industry Trends

Policy / Market Trends

The Blues Announce Milestone in Progress to Improve Prior Authorization

BCBSA [announced](#) that participating Plans are adopting a standardized approach for providers submitting electronic prior authorization requests for the majority of medical services.

Why this matters: The standardized approach creates a more consistent submission process for providers, reducing confusion and bringing faster answers for patients. This is an important step that moves the system closer to real-time responses as additional commitments take effect in 2027.

The details: Building on [changes already underway in 2026](#), the initiative advances a common set of standards for electronic prior authorization for frequently prior authorized medical services, such as major orthopedic surgeries and advanced imaging like CT scans and MRIs. Instead of navigating formats for requirements from plan to plan, providers will have a more transparent and consistent process when submitting electronic requests.

- These efforts apply across all lines of business, including commercial coverage, Medicare Advantage and Medicaid managed care, with implementation determined by each participating plan.

What they're saying: "To deliver a truly streamlined experience, our partnership with providers is critical," said Kim Keck, president & CEO, BCBSA. "Looking ahead to 2027, we anticipate continued collaboration with health systems and CMS to ensure we collectively embrace approaches that move at the speed of care to create a better system of health."

Zoom out: This update is the latest step in the [multi-year commitments](#) The Blues and other health plans made in 2025 to improve prior authorization. Since those commitments took effect, we have reduced prior authorization requirements by 11%, eliminating 6.5 million prior authorizations for patients across a range of medical services.

The bottom line: These changes help speed access to evidence-based treatments, better support people who switch health plans and improve communications about decisions and options.

Dig deeper: Read the [joint press](#) release with AHIP and recent Axios [coverage](#).

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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