Highmark's Weekly Capitol Hill Report



Issues for the week ending October 30, 2026

Federal Issues

Regulatory

Department of Labor Releases PBM Fee Disclosure Final Rule

What's happening: The Department of Labor (DOL) released its Final Rule entitled "Improving Transparency into Pharmacy Benefit Manager Fee Disclosure" along with a press release.

Why this matters: The Final Rule significantly expands existing compensation disclosure requirements for service providers to large, self-insured employer-sponsored group health plans under Section 408(b)(2) of the Employee Retirement Income Security Act by requiring providers of pharmacy benefit management (PBM) services to disclose information about their compensation to fiduciaries of group health plans.

- The requirements are applicable for plan years beginning on or after July 1, 2027.
- The Final Rule implements amendments to ERISA section 408(b)(2)(B) enacted by section 6702 of the H.R. 7148, the 2026 Consolidated

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Regulatory

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Appropriations Act (CAA, 2026), while retaining detailed PBM-specific disclosure requirements that insurers are continuing to evaluate for alignment with the broader CAA framework.



Departments Release Guidance on Surprise Billing Batching and Bundling Requirements

What's happening: The Departments of Health and Human Services, Labor and the Treasury (Departments) released guidance on batching and bundling requirements in the Independent Dispute Operations (IDR) process. This guidance provides additional detail and examples to support IDR entities (IDREs) and disputing parties as they operationalize the batching and bundling requirements established earlier this year in the IDR Operations Final Rule.

Why this matters: As Plans prepare for new batching requirements to take effect on Nov. 1, this additional guidance provides clarifications on how the requirements will be applied in practice.

The details: The guidance explains how to implement the finalized batching requirements and identifies the permissible CPT code ranges for anesthesiology, radiology, pathology, and laboratory items and services eligible for batching because they relate to the treatment of a similar condition. The guidance also provides examples to clarify how disputing parties and IDREs should apply the finalized batching and bundled payment provisions.

The bundling provisions took effect on Aug. 3, 2026.

Federal Court Vacates CMS' Ability-to-Comply Test for Medicaid Community Engagement Requirements

What's happening: On October 29, 2026, a federal district court in *Commonwealth of Massachusetts v. Oz* (D. Mass.) vacated a requirement included in the Centers for Medicare & Medicaid Services' (CMS) June interim final rule with comment period (IFC), Medicaid Program; Community Engagement Requirement for Certain Individuals.

- The requirement directed individuals who meet a statutory medical-frailty category to demonstrate that their condition also significantly impairs their ability to comply with Medicaid community engagement requirements.
- The court held that qualifying for the exclusion cannot depend on a separate ability-to-comply test.

- The ruling does not change the January 1, 2027 implementation date for the underlying Medicaid community engagement requirements. The lawsuit was filed by a coalition of 25 states and the District of Columbia.

The details:

- **The separate ability-to-comply test was vacated.** The court held that meeting a statutory medical-frailty category cannot be conditioned on an additional showing that the individual is unable to satisfy the community engagement requirement.
- **The IFC's other verification limits remain.** The court upheld the 12-month lookback on claims and encounter data and the limit of one self-attestation per continuous period of enrollment.
- The plaintiff states and D.C. received six months of protection from federal penalties for implementation errors or delays. CMS may not penalize them for errors or delays in implementing the IFC for six months from October 29, 2026. This protection does not postpone the January 1, 2027 implementation date for the underlying community engagement requirements.

Why this matters: For members who meet a statutory medical-frailty category, the ruling removes the additional requirement to prove that their condition prevents them from meeting the community engagement requirement. The category-specific criteria, the 12-month lookback, and the self-attestation limit remain, so timely claims and encounter data, along with support for members who need additional documentation, are still important.

The ruling comes late in the implementation process, as states are preparing to implement the underlying community engagement requirements beginning January 1, 2027. It may require changes to systems and processes already under development. States will still need direction from CMS on how to adjust implementation. The parties generally have 60 days from the October 29 judgment to file a notice of appeal.

An appeal, a request to stay the decision, subsequent court orders, or CMS guidance could change the implementation picture.

Please see below for relevant links related to this update:

- **Judgment**
- **Order of Vacatur and Enjoinment**

BCBSA Weighs in on MedPAC's MA Provider Directory Review

BCBSA responded to a recent discussion by the Medicare Payment Advisory Commission (MedPAC) comparing Medicare Advantage (MA) provider directory data with records of patients' visits.

- MedPAC is an independent, nonpartisan agency that advises Congress on Medicare policy and payment issues, and its work is used to inform and influence future legislation.

Why this matters: Early findings from MedPAC's analysis show differences between MA provider directories and records of patients' visits — or encounter data. The findings may prompt policymakers in

Congress or CMS to consider new policies on a variety of issues: provider directory accuracy, reporting, validation, network adequacy and how beneficiary access is measured in MA.

The details: BCBSA's comments focused on three key themes:

- **Encounter data alone cannot measure directory accuracy.** BCBSA urged MedPAC to recognize that discrepancies may reflect billing arrangements, provider organizational structures, timing differences, or data matching limits, not actual directory errors.
- **More analysis and stakeholder engagement are needed.** BCBSA encouraged MedPAC to further assess its methodology and work with plans and providers to better understand the causes of discrepancies before making recommendations.
- **Directory accuracy is a shared responsibility.** BCBSA emphasized that health plans, providers, health systems and delegated entities all play a role in maintaining accurate provider information. They also encouraged MedPAC to consider solutions that improve the provider data ecosystem, including a National Directory of Healthcare Providers and Services or similar centralized data hub.

CMS Directs Issuers to End Post-Enrollment Agent-of-Record Changes

What's happening: CMS issued guidance titled "Issuer 'Agent-of-Record' Processes." The guidance clarifies that qualified health plan (QHP) issuers should no longer operate the type of post-enrollment agent attribution processes described in the 2017 Letter to Issuers in the Federally-facilitated Exchanges (FFEs).

Why this matters: Under the guidance, agent-of-record attribution would be fixed at the point of enrollment, when consumer consent is documented. CMS states that allowing post-enrollment changes creates an opportunity for an agent to become the agent-of-record without the consumer's knowledge or consent. CMS believes that removing this window will reduce the risk of unauthorized enrollments. The guidance applies to the FFEs and State-based Exchanges on the Federal Platform (SBE-FPs)

The details: Key details of the guidance include:

- **What was permitted under the 2017 Letter to Issuers.** Previously, CMS expected an issuer would compensate an affiliated, FFE-registered agent or broker if the issuer's, agent's, or broker's records showed the agent or broker assisted the consumer but the NPN was erroneously left off the 834 enrollment transaction. CMS now states that issuers should no longer operate processes like those described in the 2017 Letter.
- **Activity that is no longer permitted.** Issuers should not allow an agent or broker whose NPN is not listed in the original enrollment data sent by CMS to claim credit for the enrollment by later submitting evidence, such as an agent-of-record or broker-of-record form, that the consumer had entered into a relationship with the agent or broker.
- **What remains permitted.** Issuers may still work with agents, brokers, and CMS to facilitate legitimate book of business transfers, as described in the FFE Enrollment Manual. In addition, to the extent permitted by law, issuers may continue to enter into contractual relationships with agents, brokers, and agencies under which the issuer provides compensation for enrollments completed by a specific agent or broker to another agent, broker, or agency.

Go deeper: For additional guidance on QHP issuer oversight of agents and brokers as it relates to compensation, CMS refers readers to the 2016, 2017, 2018, 2026, and 2027 Letters to Issuers in the FFEs.

HHS Codifies Statutory Exclusions from the Definition of Disability

The final rule amends the definition of disability under Section 504 of the Rehabilitation Act to exclude gender identity disorders not resulting from physical impairments

What's happening: The U.S. Department of Health and Human Services (HHS) released a final rule titled "Nondiscrimination on the Basis of Disability in Programs or Activities Receiving Federal Financial Assistance," that amends Section 504 of the Rehabilitation Act of 1973 (Section 504) and codifies statutory exclusions from the definition of disability.

Why this matters: Section 504 prohibits discrimination from programs that receive federal funding against individuals based on their disability. In a press release issued alongside the final rule, HHS states that the update to a 2024 final rule is necessary to resolve ambiguity and ensure the rule aligns with the best reading of the law.

The details: The final rule limits access to gender affirming care and follows a directive from President Trump in his Executive Order: "Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government."

According to HHS, the final rule serves multiple goals:

- Updates HHS Section 504 regulation to identify the conditions Congress excluded from the definitions of "disability" and "individual with a disability."
- Clarifies that gender dysphoria not resulting from physical impairments is excluded from coverage.
- Clarifies the existing obligations of organizations and entities that receive HHS funding.

The final rule is scheduled to be published in the Federal Register on Nov. 3, 2026, and will be effective 60 days later.

HHS Issues Enforcement Discretion for Maternity Care Episodes Spanning 2026 and 2027

The Department of Health and Human Services (HHS) issued **enforcement discretion** allowing HIPAA covered entities to keep using the legacy CPT 2026 **Maternity Care Services** codes for Maternal Care Service episodes of care in which services begin in 2026 and end in 2027.

The **letter** relies on HHS's enforcement discretion under 45 CFR § 162.1101. It allows covered entities to use the legacy 2026 codes outside their valid date range for these episodes for billing and payment from January 1 through December 31, 2027, even though the new CPT 2027 Maternity Care Services coding structure takes effect January 1, 2027. Beginning January 1, 2027, HHS will not take HIPAA enforcement action against covered entities that follow a health plan's business rules for using the 2026 codes.

Health plans may now issue business rules instructing providers, clearinghouses, and other trading partners how to report these maternal episodes which span both years. Note, the guidance **permits** plans to direct the use of the 2026 codes, but does not require plans to issue such business rules. The letter states that business rules should minimize disruption for providers, result in accurate provider payment, and be phased out as soon as operationally feasible in 2027.

Next Steps: The letter notes that it does not constitute CMS payment policy. The CY 2027 Physician Fee Schedule final rule, which will likely be released this week, will indicate whether CMS finalizes the proposed HCPCS G-codes for maternity care, what the relative value units will be for any finalized codes, etc.

Enforcement Discretion Resources

- HHS guidance letter
- AMA CPT 2027 maternity care services code changes

CMS Updates

- **OIG Identifies Potential Vulnerabilities in Medicare Part B Outpatient Drug Billing:** On Oct. 28, the Department of Health and Human Services Office of Inspector General (OIG) issued a report identifying potential vulnerabilities in the Centers for Medicare & Medicaid Services' (CMS') oversight of Medicare Part B outpatient drug billing. OIG analyzed claims with dates of service from April 2024 through March 2025 and identified 160,918 claim lines in which procedure codes for outpatient drugs did not match the procedure codes associated with the drug codes in CMS crosswalk files. OIG found CMS and Medicare Administrative Contractors did not have system edits to ensure providers used the appropriate procedure codes and provider education did not address this issue.

  Why this matters: The report does not make specific recommendations to CMS but states the findings may inform future oversight.

- **CMS to Expand CGT Access Model Beyond Sickle Cell Disease** : The Centers for Medicare & Medicaid Services (CMS) announced it is planning to expand its Cell and Gene Therapy (CGT) Access Model framework beyond sickle cell disease following positive initial results from the first model evaluation report. CMS plans to release a request for applications (RFA) in the coming months inviting manufacturers of other cell and gene therapies to participate in the model.

- **CMS Releases Work Requirements Implementation Mitigation Strategy Memo to States :** CMS recently provided checklists of mitigation strategies states may opt to implement as they prepare their verification systems to be compliant with Medicaid work requirements. The three checklists CMS provided focus on: 1) difficulties states are encountering with implementing work requirements (e.g., lack of reliable data sources to confirm whether enrollees are meeting requirements) alongside mitigation strategies states could adopt (e.g., permitting self-attestation as a verification option in accordance with CMS guidelines); 2) challenges states may have with underlying enrollment processes (e.g., application, renewal, and fair hearing procedures); 3) optional strategies states can implement to address "significant operational and systems challenges." States are required to follow their CMS-approved mitigation plans to avoid penalties. States must also submit quarterly updates and provide timelines for achieving full compliance.

- **CMCS Releases Roadmap of Key Implementation Dates :** The Center for Medicaid and CHIP Services (CMCS) released a "Roadmap of Select Medicaid and CHIP Policy Implementation Dates," an interactive resource detailing the implementation of "selected final rules and statutes that may require changes to state Medicaid Enterprise Systems (MES)." The roadmap allows users to view all upcoming implementation dates for key MES changes on a single timeline and filter by the type of system that must be updated, such as states' websites or eligibility and enrollment systems, as well as by the governing statute, such as the FY 2025 budget reconciliation law, or by the relevant regulation. CMCS notes the timeline is not intended to be inclusive of all regulations or statutes that may impact the Medicaid and CHIP programs, "but instead focus on ones that might have potential systems impacts," and cautions "that these actions may impact each state and territory differently."

Industry Trends

Policy / Market Trends

Medicaid Managed Care Enrollees Report Better Care Experiences Than Fee-for-Service Beneficiaries, MHPA Analysis Finds

A new research brief from Medicaid Health Plans of America (MHPA) finds Medicaid beneficiaries in states that primarily use managed care report better experiences with their health care, health plans, and providers than beneficiaries in states that rely primarily on fee-for-service (FFS) delivery systems. The analysis examined 2024 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data reported through the Centers for Medicare & Medicaid Services (CMS) Child and Adult Core Sets.

Why this Matters: The findings come as policymakers continue to debate the role of managed care in Medicaid and consider reforms aimed at improving beneficiary experience and outcomes. MHPA argues the results demonstrate managed care organizations can enhance enrollee satisfaction through coordinated care, provider engagement, and accountability mechanisms built into Medicaid managed care contracts. The report may provide additional support for states considering expanded use of managed care models and for plans highlighting their role in improving the beneficiary experience.

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/

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