Highmark's Weekly Capitol Hill Report

Issues for the week ending April 17, 2026

Federal Issues

Legislative

Updates from Capitol Hill

- **Senate Prepares to Move Forward on Budget Reconciliation**
  The Senate announced it would initiate procedures to consider a budget resolution, the first step to consideration of a second budget reconciliation package. The move is necessary because Democrats will not vote for Homeland Security funding without reforms to Immigration and Customs Enforcement. It is expected to be narrowly targeted to funding parts of the Department of Homeland Security. Once the budget resolution is released, the committees instructed will provide some insight into the scope of the package.

- **OMB Testifies on President's FY2027 Budget**
  Last week, Office of Management and Budget (OMB) Director Russell Vought testified before the House and Senate Budget Committees on the President's FY 2027 budget. House Budget

In this Issue:

Chairman Jodey Arrington (R-TX) focused on the national debt inherited from the Biden Administration, arguing Republicans have reduced inflation and addressed cost pressures through H.R, 1, the One Big Beautiful Bill Act. Senate Budget Chairman Lindsey Graham (R-SC) focused his remarks on areas outside of health.

House Budget Committee Ranking Member Brendan Boyle (D-PA) criticized the Administration's economic record and cited the Congressional Budget Office's (CBO) projections that H.R. 1 would result in 15 million coverage losses. While both chambers focused their remarks on projected coverage losses and proposed cuts to health care, Senate Democrats raised particular concern about restructuring behavioral health programs into block grants.

Director Vought defended the Administration's deficit-reduction strategy, questioned CBO's reliability, and stated individuals losing coverage could gain employer-sponsored insurance through new Medicaid work requirements.

Regulatory

- **Insurance Department Announces Results of the External Review Process**

Industry Trends

Policy / Market Trends

- **State Regulators Seek Guardrails for Level-funded Plans From DOL**
- **NAIC Guide Addresses Shifting ERISA Preemption Tensions Over State PBM Rules**
- **The Impact of Rising Hospital Costs**
- **Wakely Report on the Decline in ACA Individual Market Enrollment for 2026**
- **MACPAC Issues Draft Recommendations & Releases Issue Brief**

- **RFK Testifies on President's FY2027 Budget**
  Last week, HHS Secretary Robert F. Kennedy Jr. (RFK) testified before the House Labor, HHS, and Education Appropriations Subcommittee, the House Ways and Means Committee, and the House Education and Workforce Committee on the FY2027 HHS budget.

  At the appropriations hearing, Chairman Robert Aderholt (R-AL) applauded the Make America Healthy Again (MAHA) agenda, raised concerns about rural hospital closures and affirmed support for the National Institutes of Health (NIH), despite budget constraints. Ranking Member Rosa DeLauro (D-CT) criticized the proposed $16.5 billion cut to health agencies, leadership departures at the CDC and Medicaid cuts under H.R.1. Representative Andy Harris (R-MD) criticized the 2% Medicare Advantage premium increase and cited upcoding concerns. Secretary Kennedy highlighted efforts to reduce chronic disease, reform prior authorization, combat fraud, waste, and abuse and lower drug costs, framing budget cuts as necessary for deficit reduction.

  At the Ways and Means hearing, Chairman Jason Smith (R-MO) highlighted rising health care spending driven by chronic disease and misaligned incentives, arguing for a shift toward prevention, nutrition, and wellness. He applauded the Secretary for his MAHA leadership and sharply criticized industry consolidation and vertical integration, asserting that insurer profits and overall costs have increased under the ACA without corresponding improvements in access or quality, and warned that hospitals will face similar scrutiny for higher prices without better outcomes. In his questioning, Smith focused on rural hospitals, pressed the administration to finalize the surprise billing rule, and emphasized the committee's work on site neutral payment reform.

  Ranking Member Richard Neal (D MA) cited Massachusetts as a bipartisan model for health care reform, stressing that gains in coverage and affordability require cooperation and should not be dismantled. He emphasized the science supporting measles vaccinations, warned that proposed cuts would force families to choose between health care and childcare, highlighted Medicare drug price negotiations as historic price relief. He raised concerns about Medicare fraud and defended the No Surprises Act, pushing back on the Secretary's criticism of the Biden administration's implementation.

  At the House Education & Workforce Committee hearing, Chairman Tim Walberg (R-MI) applauded HHS for addressing rising health care costs, chronic disease, and declining public trust, and emphasizing price transparency to drive competition and lower costs. He praised the new dietary guidelines, stressed protecting early childhood programs from waste, fraud and abuse, and called for elimination of DEI mandates and policies that promote gender-related medical interventions for minors.

  Ranking Member Bobby Scott (D-VA) criticized cuts the proposed 12.5% reduction to HHS, warning it would raise costs and reduce coverage. He raised concerns about cuts to CDC, NIH, and the elimination of the Low-Income Home Energy

Assistance Program and the Administration for Community Living, and reductions to Medicaid-funded home- and community-based services, urging the administration to focus on affordable care and support for childcare and disability programs.

- **Senate HELP Committee Examines Rx Pricing**
  On Thursday, the Senate HELP Committee held a hearing on increasing competition to lower prescription drug costs. Chairman Bill Cassidy (R-LA) endorsed both bills in his opening remarks and discussed his newly released "Money and Value for Patients (MVP)" agenda. He emphasized the need to lower drug costs while encouraging innovation and called for increased oversight and reforms to PBMs, noting that generics often struggle to gain formulary access. Ranking Member Bernie Sanders (I-VT) argued that the U.S. prescription drug pricing system is fundamentally broken, citing polling showing most Americans believe prices are unreasonable and criticizing the Trump administration for falsely claiming it lowered drug prices while companies continued to raise them. He noted that the U.S. pays the highest prices in the world, blaming pharmaceutical monopolies and industry lobbying, and advocated for direct government negotiation and international reference pricing to cut drug costs.

  Witnesses broadly agreed that greater competition, more transparency from drug manufacturers and decentralized clinical trials could help lower costs. Witnesses also agreed that the pharmaceutical companies have outsized political influence and argued that reforming the citizen petition process and reducing pre-market requirements would lead to lower prices.

  In conjunction with the hearing, the Ranking Member released a report finding that pharmaceutical companies that signed drug pricing deals with President Trump continued to raise prices on hundreds of drugs and launched new medications averaging $353,000 per year. The report shows industry profits reached $177 billion in 2025, up from $107 billion in 2024, and links high prices to practices that limit competition, including patent abuse and delayed generic or biosimilar entry, alongside record executive compensation.

- **Democratic Health Leaders Send Additional Letters to Pharma**
  On April 13, Energy and Commerce Committee Ranking Member Frank Pallone, Jr. (D-NJ), Ways and Means Committee Ranking Member Richard E. Neal (D-MA), Education and Workforce Committee Ranking Member Robert C. "Bobby" Scott (D-VA), and Senate Finance Committee Ranking Member Ron Wyden (D-OR) sent additional letters to 11 major pharmaceutical companies requesting information on their Most Favored Nation (MFN) deals with the Trump Administration regarding the cost of medications.

  Last December, Ranking Members Pallone, Neal, Scott and Wyden sent letters to AstraZeneca, Eli Lilly, Novo Nordisk, and Pfizer requesting information on their MFN deals and the effect on Medicare, future pricing, and the TrumpRx platform. Members also inquired about additional benefits that these companies may experience because of the agreements.

Federal Issues

Regulatory

CMS Moves to Expand Electronic Prior Authorization, Tighten Oversight

On April 10, CMS released the 2026 Interoperability Standards and Prior Authorization for Drugs proposed rule.

> **Why this matters:** The proposal would significantly expand payer requirements around electronic PA and data sharing — with implications for operational readiness, system investments and ongoing compliance monitoring.
>
> - The rule also signals CMS' continued push for greater standardization and transparency in how interoperability tools are implemented and used across markets.

The details: The proposal, which would apply to Medicare Advantage, Medicaid, CHIP and federally facilitated exchange plans, builds on previous federal rules and **includes these key provisions:**

- **Electronic PA requirements** would be expanded to include prescription drugs using standardized interoperability approaches already required for other types of care.
- **Interoperability requirements** would broaden, extending existing API-related PA policies to additional entities, including small group market issuers on the federal SHOP exchanges.
- **Oversight of interoperability implementation** and use would increase by requiring payers to report data-sharing systems directly to CMS, which would track adoption, use and performance.

> **BCBSA's take:** BCBSA is generally supportive of these proposals, which align with our PA commitments to streamline and modernize electronic PA and their broader North Star goal of delivering a convenient, seamless experience for consumers, customers and providers.

The proposed rule also extends many of the requirements in the 2024 Interoperability and Prior Authorization final rule to include drug coverage rules and documentation requirements by October 1, 2027.

Other Provisions:

- Replaces the X12 standards with Fast Healthcare Interoperability Resources® (FHIR®) standards for prior authorization requests and responses.
- Requires payer reporting of API endpoints, prior authorization actual numbers, and additional API usage metrics.
- Requires use of previously recommended standards and implementation guides for Interoperability APIs.

Effective Date: CMS proposes compliance dates generally beginning in 2027.

Requests for Information: The rule also includes five Requests for Information covering care coordination event notifications, cybersecurity, API oversight, step therapy, and prior authorization for lab tests and DMEPOS.

Dive Deeper: See the proposed rule, fact sheet, and press release.

Next steps: Comments are due June 15, 2026.

AHIP & BCBSA Submit Comments on DOL PBM Fee Disclosure Proposed Rule

AHIP submitted comments to the Department of Labor on the Improving Transparency Into Pharmacy Benefit Manager (PBM) Fee Disclosure proposed rule.

Why it matters: If finalized, the proposed rule would significantly expand existing PBM compensation reporting requirements to employer health plan fiduciaries under Employee Retirement Income Security Act (ERISA).

- The proposed rule's reporting requirements would also overlap with new Consolidated Appropriations Act (CAA) 2026 provisions, putting health plans at risk of conflicting compliance obligations.

Key Excerpt: "AHIP supports many of the proposed disclosures from PBMs to health plan sponsors, as they would support greater competition and demonstrate the value of health plans and PBMs in ameliorating drug manufacturers' high list prices. However, following the enactment of the significant new PBM transparency statutory requirements enacted under the Consolidated Appropriations Act of 2026 (CAA, 2026), we encourage the Department to withdraw the proposed rule and engage in future rulemaking consistent with the new statutory provisions."

Other Recommendations Include:

- If any rulemaking is finalized, DOL should narrowly tailor any PBM disclosure requirements to the CAA's express purpose: helping plan sponsors evaluate compensation reasonableness. AHIP recommends the rescission of non-CAA definitions and the proposed requirement to provide estimated disclosures.

- Any final rule should align with the implementation timeline of the CAA, allowing reporting entities one full year after publication before implementation.

- Any final rule should ensure that plan sponsors that participate in the drug supply chain cannot use disclosures for anticompetitive purposes.

BCBSA also urged DOL to withdraw its proposed PBM fee disclosure rule, citing overlapping requirements with Consolidated Appropriations Act 2026 (CAA) provisions and conflicting compliance obligations for BCBS Plans.

If finalized, BCBSA recommended:

- Narrowing the rule's scope,

- Scaling back disclosure requirements to match congressional intent,

- Delaying implementation, and

- Removing audit provisions that exceed DOL's authority and called for a good faith safe harbor to protect plans and service providers during the CAA compliance transition.

DOJ National Fraud Enforcement Division — Medicare Enforcement Structure

On April 7, Acting Attorney General Todd Blanche issued a memorandum formally establishing the National Fraud Enforcement Division (NFED) within the Department of Justice, placing the Health Care Fraud Unit, the Tax Section, and the Market, Government, and Consumer Fraud Unit under its direct operational control. The NFED, first announced by Vice President Vance in January, is a new standalone litigating division with a mandate to take a centralized, coordinated approach to fraud against taxpayer-funded programs including Medicare and Medicaid. Each U.S. Attorney's Office is required to designate an experienced prosecutor to be detailed to the NFED within 21 days, effectively embedding enforcement priorities in every federal district. MA organizations and DME suppliers should anticipate continued scrutiny and should ensure compliance programs are designed to detect billing irregularities and potential Anti-Kickback Statute violations.

CMS Releases FY 2027 Medicare Hospital IPPS Proposed Rule

On April 10, CMS released a proposed rule updating the Medicare Inpatient Prospective Payment System (IPPS) for fiscal year (FY) 2027.

Key Highlights

- **Payment Updates:** The rule proposes a 2.4% increase in inpatient payment rates for hospitals that meet quality reporting and EHR requirements, reflecting a projected 3.2% market basket update less a 0.8 percentage point productivity adjustment. Overall, for FY 2027, CMS expects the proposed changes in IPPS

payment rates — in addition to other changes — will increase hospital payments by approximately $1.4 billion.

- **Expansion of the Comprehensive Care for Joint Replacement (CJR) Model:** The proposed rule creates the CJR Expanded (CJR-X) Model, a 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. The significant expansion of CJR-X, to become mandatory nationwide beginning October 1, 2027 — the first mandatory, nationwide episode-based payment model.

- **Updates to Quality Reporting and Value-Based Purchasing Programs:** The proposed rule includes numerous updates to specific programs under IPPS, including provisions involving interoperability, hospital readmissions, hospital value-based purchasing, and more.

Dive Deeper: See the unpublished proposed rule and CMS fact sheet.

Mental Health Parity Update

HHS, the DOL and Treasury have decided not to defend the 2024 final mental health parity rule and instead will issue a new proposed rule by the end of 2026.
The decision comes after two years of advocacy to rescind the final rule by various stakeholders.

Next Steps: Looking ahead, BCBSA, AHIP and the Association for Behavioral Health and Wellness are finalizing a joint set of recommendations, which they will share with the Departments in the coming weeks.

CMS Updates

- **CMS Releases Medicaid and CHIP Policy Implementation Roadmap:** The Center for Medicare & Medicaid Services (CMS) released the Medicaid and Children's Health Insurance Program (CHIP) policy implementation roadmap to assist states with implementation and planning efforts. CMS developed the roadmap to identify key provisions from selected final rules and statutes that may require modifications to state Medicaid Enterprise Systems (MES).
  The roadmap includes a "high-level" timeline review and a "detailed" timeline review to ensure state compliance with new or updated Medicaid policy, and emphasizes policy and technology requirements that are most likely to have implications on state systems.

- **RxDC Crosswalk:** CMS released an updated Prescription Drug Data Collection drug name and therapeutic class crosswalk (RxDC Crosswalk) for the 2025 reference year. The Health Insurance Oversight System (HIOS) began accepting submissions for the 2025 reference year on April 10, 2026. The deadline for submitting RxDC filings for the 2025 reference year is June 1, 2026.

- **CMS Releases PY2027 QHP Application Materials, Revised Timeline Bulletin**: CMS posted Plan Year (PY) 2027 Qualified Health Plan (QHP) Application Materials to the QHP certification website.

  CMS also released an updated PY2027 QHP Data Submission and Certification Timeline bulletin, which separates the opening of the QHP Application data validation window from the QHP Application submission window.

  Why this matters: The materials reflect guidance detailed in the proposed 2027 Notice of Benefit and Payment Parameters, and the 2027 Draft Letter to Issuers in the Federally-facilitated Exchanges (FFEs). Issuers applying for certification for QHPs, including stand-alone dental plans, should use these posted materials when applying for certification to participate in the Federally-facilitated Exchange (FFE).

Advisory Committee on Immunization Practices (ACIP) Update

Department of Health and Human Services (HHS) Secretary Robert F. Kennedy Jr. has signed an updated charter document for the Advisory Committee on Immunization Practices (ACIP) that underscores its role in considering vaccine safety risks and broadens membership qualifications.

Why this matters: The changes are drawing criticism from some medical and public health organizations believing the changes alter the committee's mission and membership structure. ACIP remains effectively stalled with no new meeting announced this week and prior legal/policy disputes still unresolved.

Meanwhile, a handful of democratic led states, including Maryland, California, Colorado and Maine, have taken steps to remove ACIP's influence in state laws. The changes are intended to insulate the states from volatility, but they're also likely to exacerbate the divide between red and blue states' immunization policies.

ACIP's recommendations are often embedded in state laws, affecting policies such as vaccine requirements for school attendance and health care workers, as well as for insurance coverage.

The states' updates are unlikely to have much of an effect until HHS decides how to move forward amid the recent federal ruling, which temporarily blocked the appointment of new members selected by Secretary Kennedy and any changes to the immunization schedule.

As a reminder, BCBS Plans have committed to cover all ACIP-recommended immunizations with no cost-sharing through 2027, while operating within federal and state laws and meeting program and customer requirements.

President Picks Former Deputy Surgeon General to Lead CDC

President Trump has named a former U.S. Deputy Surgeon General, Erica Schwartz, M.D., to lead the CDC. Dr. Erica Schwartz is also a retired rear admiral in the U.S. Public Health Service Commissioned Corps. She is a board-certified physician in preventive medicine and has over 20 years of federal public health service across the U.S. Navy, the Public Health Service Commissioned Corps, and the U.S. Coast Guard.

Next steps: Schwartz will now go through the Senate confirmation process.

State Issues

Pennsylvania

Legislative

Legislative Update

The Senate returns this week for a three-day voting session with no oversight committees holding any hearings or votes.

The House Health Committee last Tuesday held a voting meeting to consider, amongst other bills and non-controversial resolutions, House Bill 836 by Representative O'Mara. This legislation seeks to preserve access to Assisted Reproductive Technology within the Commonwealth. There was a technical amendment further clarifying definitions which was adopted unanimously, with the bill then being voted favorably from committee by a 17-9 vote.

House Bill 916 by Representative Giral was scheduled for a vote but was passed over due to a forthcoming technical amendment. This legislation would amend the Childhood Blood Lead Test Act and has since been rescheduled for a vote on Tuesday, April 28th.

After Wednesday the Senate will adjourn until May 4th, with the House returning on April 27th.

Regulatory

Insurance Department Announces Results of The External Review Process

The Pennsylvania Insurance Department (PID) recently announced that, since 2024, the Commonwealth-run Independent External Review process has overturned about 48% of eligible denied claims submitted by Pennsylvanians.

PID has referred 1,353 eligible cases for an external review through an Independent Review Organization (IRO) since the process started in 2024. Of those requests, 655 initially denied insurance claims were overturned by independent reviewers.

This external review process provides for a review of adverse benefit determinations following exhaustion of internal appeals. The process applies only to commercial

insurance policies purchased directly from an insurer, through Pennie (Pennsylvania's health insurance marketplace), or through employers offering insured plans, and does not apply to self-funded health benefit plans.

The full article can be viewed here: https://www.pa.gov/agencies/insurance/newsroom/shapiro-admin-ind-ext-review-helps-hundreds-receive-benefits-originally-denied

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Industry Trends

Policy / Market Trends

State Regulators Seek Guardrails for Level-funded Plans From DOL

BenefitsPRO reports state insurance regulators are urging the U.S. Department of Labor (DOL) to clarify how **federal law applies to level-funded health plans**, amid concern these plans are growing rapidly while falling into regulatory gray areas between fully insured and self-funded coverage. The issue was raised by a working group of the **National Association of Insurance Commissioners (NAIC)** in early April 2026.

Level-funded plans—hybrid arrangements that combine aspects of self-funding with stop-loss insurance—are typically treated as **ERISA self-funded plans**, meaning they are largely exempt from state insurance regulation. State regulators argue, however, some level-funded arrangements resemble fully insured products and may be marketed to small employers without the consumer protections that apply to traditional insurance.

The NAIC working group is seeking "guardrails" from the DOL to help determine:

- When a level-funded plan should clearly be treated as self-funded under ERISA
- Whether certain plan designs or marketing practices undermine ERISA's intent
- How stop-loss insurance features influence regulatory classification

Regulators expressed concern the lack of federal guidance could allow carriers and administrators to design products that **shift risk back to insurers while avoiding state oversight**, potentially weakening solvency protections and benefit standards established in state law.

NAIC members emphasized they are not seeking to dismantle ERISA preemption, but rather to understand how the DOL interprets existing law as level-funded plans proliferate, particularly among small and mid-sized employers. They want to avoid regulatory gaps that could expose employers or workers to unexpected risk if a plan fails or is poorly structured.

The article notes level-funded plans have become increasingly popular as employers look for cost control and premium stability, drawing greater attention from regulators who

worry inconsistent oversight could create **consumer protection and market-fairness issues** if federal and state roles are not better aligned.

NAIC Guide Addresses Shifting ERISA Preemption Tensions Over State PBM Rules

State insurance regulators are cautioning the legal landscape around **ERISA preemption and state regulation of pharmacy benefit managers (PBMs)** remains unsettled, even after several high-profile court decisions. In response, the **National Association of Insurance Commissioners (NAIC)** has released a new guide intended to help regulators understand when state PBM laws may survive or be blocked by ERISA. The issue was discussed at an NAIC meeting in early April 2026.

The guide explains that while the U.S. Supreme Court's 2020 decision in **Rutledge v. Pharmaceutical Care Management Association** gave states more room to regulate PBMs, it did not create bright-line rules. Rutledge held ERISA does not automatically preempt state laws that merely affect plan costs, but subsequent federal appellate rulings have reached mixed conclusions when PBM laws are seen as interfering with plan administration.

Because of this uncertainty, NAIC regulators emphasized the subject is too fluid to be folded into the organization's standard ERISA reference materials. **Instead, the new guide walks through:**

- Key court cases shaping ERISA preemption analysis
- Common features of state PBM laws that have triggered legal challenges
- Factors courts consider when deciding whether a law regulates PBMs versus ERISA plans themselves

The guide highlights that **minor differences in statutory design**—such as reporting requirements, reimbursement rules, or network mandates—can determine whether a state PBM law is upheld or struck down. Recent appellate court decisions have invalidated some PBM laws while allowing others to stand, reinforcing concerns about inconsistency across jurisdictions.

NAIC officials said the purpose of the guide is not to advocate for a specific regulatory outcome, but to help states better anticipate legal risks as they pursue PBM reforms aimed at reducing drug costs and increasing transparency. Regulators acknowledged ERISA preemption remains one of the biggest obstacles to meaningful state-level PBM oversight, particularly for **self-funded employer plans**, which are primarily regulated at the federal level.

Overall, **ERISA preemption battles over PBM regulation are far from settled**, and state lawmakers and regulators must proceed carefully as courts continue to shape the boundaries of federal versus state authority in this area. Read more here.

The Impact of Rising Hospital Costs

Below are two new articles spotlighting recent media coverage of how rising hospital costs are contributing to the health care affordability pressures millions of Americans are facing.

WSJ: Higher Hospital, Provider, and Drug Prices 'The Main Cause' of 'Why the U.S. Spends So Much on Health Care'

A new report by *The Wall Street Journal* examines why "Americans spend more on health care than anyone else in the world," underscoring "the high prices Americans pay for surgeries and drugs" compared to consumers in other nations.

- *Key Excerpt:* "Big hospitals can charge higher rates because of consolidation … Many cities and communities are now dominated by a single hospital system, partly because hospitals have been merging in recent years. The consolidation has given hospital systems leverage to command higher rates during negotiations with health insurers. The insurers would lose business if powerful hospitals shut them out."

NBC News: 'Hospital Costs Are Rising Far Faster Than Inflation and Drowning Americans in Debt'

A new investigative report by NBC News underscores how hospital systems' anticompetitive consolidation, ever-higher prices, and opaque billing practices are raising health care costs and driving the ongoing affordability crisis.

- *Key Excerpt:* "Hospital costs are among the major forces driving Americans deeper into debt and widening the inequality gap. Over the past two decades, those costs have risen far faster than any other sector of the U.S. economy, said Zack Cooper, associate professor of public health at Yale University. Paying for hospital care is 'the leading driver of health spending growth,' Cooper said. 'And the genesis of a lot of the affordability pressure folks are feeling has to do with health care.'"

Consolidation: These recent reports come on the heels of new data from KFF showing how hospital consolidation leads to higher prices and other negative consequences.

Dive Deeper: Read AHIP's highlights on the WSJ piece here and on the NBC News piece here.

Learn more about what's driving higher premiums and how to make health care more affordable, via AHIP's Cost Connection.

Wakely Report on the Decline in ACA Individual Market Enrollment for 2026

Wakely published a new report on the decline of Individual Market enrollment for 2026, resulting from the loss of the enhanced premium tax credits: "Who Paid, and Who Stayed? Early 2026 Enrollment Trends in the Individual Market."

According to the report, Wakely estimates a reduction in enrollment in the individual market for 2026 ranging from 17% to 26%. Compared to 2025, they further estimate that morbidity could be between 2.9% and 6.5% worse in 2026.

MACPAC Issues Draft Recommendations & Releases Issue Brief

- **MACPAC Issues Draft Recommendations to Congress on MCO Performance Monitoring:** The Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission (MACPAC) issued draft recommendations to improve Medicaid managed care organization (MCO) performance data monitoring. Its recommendations to the U.S. Department of Health and Human Services include directing CMS to provide guidance on how to consistently report various types of accountability actions and directing CMS to develop a publicly available database on managed care plan performance and issue guidance and toolkits to help states effectively use these data. MACPAC also presented a draft chapter of its June 2026 report to Congress which identified barriers and opportunities in MCO oversight. Read More

- **MACPAC Releases Issue Brief on Program Integrity:** MACPAC released an issue brief on Medicaid program integrity. In the brief, MACPAC notes that while the true scale remains unknown because no data source or combination of sources captures the full extent of fraud, waste and abuse (FWA), document instances of FWA account for a portion of overall Medicaid spending. The brief also outlines the federal, state, and managed care oversight structure for Medicaid program integrity and highlights ongoing weaknesses in investigations, state oversight, and managed care monitoring, particularly given managed care's dominant role in the program. Read More

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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/.**