

Payer Policy Updates 2026 & 2027

Site of Care and Coding Controls Tighten

Payers are steering where care happens and how it is coded

Independence BC

EFFECTIVE Jun 1 & Sep 1, 2026

Redirects Care to Lower-Cost Settings

- ▶ Site-of-care review now applies to select elective hospital-based procedures and hospital outpatient surgeries as of June 2026 and CT/CTA and MR/MRA imaging as of September 2026
- ▶ Authorization can approve the service but still deny the hospital location
- ▶ Expect more services to shift from hospital outpatient departments to ASCs and freestanding centers, with added administrative work when hospital-based care requires an exception.
- ▶ Eligible fully insured Commercial PPO members when CT/CTA or MR/MRA is requested in a hospital outpatient department.

Commercial 12.06.00 / 12.06.01 • MA MA12.005 / MA12.012

TAKEAWAY: *Independence BC isn't just asking if care is necessary - it's deciding if the hospital is reimbursable.*

Highmark

EFFECTIVE March 30, 2026 (PA)

Expands Automated ED Downcoding

- ▶ Professional ED claims (99284/99285) can auto-reimburse at the 99283 rate for low-acuity diagnoses.
- ▶ Claims are processed and adjudicated with a down code that could be missed if auto-posted.
- ▶ Facility claims still face prepayment review through the Optum EDC Analyzer
- ▶ Appeals only start after payment is already reduced, so revenue loss is easy to miss

Highmark RP-037: Emergency E/M Coding Guidelines

TAKEAWAY: *These claims aren't denied - they're quietly downcoded. Without billed-to-paid monitoring, the loss hides.*

Drug Management and Federal Authorization Rules

New controls on medications, and new accountability for payers

CareFirst

EFFECTIVE Apr 1, Jul 1 & Oct 1, 2026

Expands Drug and Infusion Controls

- ▶ More medical-benefit drugs added to prior authorization and infusion site-of-care management for commercial members.
- ▶ Preferred-drug rules may require transition to a preferred drug when the current authorization expires; a medical-necessity exception may be requested once the current authorization expires
- ▶ Hospital outpatient infusion now needs justification when home or office infusion is available

CareFirst: New Medications Requiring Approval & Site of Care Management
[April Update](#) [July Update](#) [October Update](#)

TAKEAWAY: Coverage, drug choice, and site of care — CareFirst is now managing all three at once.

CMS

EFFECTIVE January 1, 2026

Prior Authorization Becomes More Transparent

- ▶ MA, Medicaid, and CHIP payers must generally decide within 72 hours (expedited) or 7 days (standard)
- ▶ Payers must give a specific denial reason and publicly report performance metrics
- ▶ Requirements cover medical items and services only — drugs are excluded

CMS-0057-F: Interoperability and Prior Authorization Final Rule

TAKEAWAY: Providers now have deadlines, denial reasons, and public metrics to hold payers accountable.

COMING IN 2027



Capitation and Federal Technology Mandates

Capitation arrives, and prior authorization goes electronic

Highmark

EFFECTIVE 2027; fee change Apr 1, 2027

Moves Primary Care Toward Capitation

- ▶ True Performance sunsets December 31, 2026; ValueBlue and ValueBlue Connect begin in 2027.
- ▶ ValueBlue uses practice-level partial capitation; ValueBlue Connect adds customizable incentives across an entity.
- ▶ ACOs and IPAs must return applicable amendments by December 1, 2026; individual practices must enroll to participate in ValueBlue Connect.
- ▶ Providers remaining solely in fee-for-service face an approximately 20% reduction on included codes beginning April 1, 2027.
- ▶ For participating practices, Highmark will calculate 2027 capitated base rates before applying the fee-schedule reduction.

Highmark: ValueBlue and ValueBlue Connect

TAKEAWAY: Participation is optional, but remaining solely in fee-for-service has a significant financial consequence—approximately 20% lower reimbursement on codes included in ValueBlue capitation

CMS

EFFECTIVE January 1, 2027

Electronic Prior Authorization Arrives

- ▶ Impacted payers must implement FHIR-based Prior Authorization, Provider Access, Patient Access and Payer-to-Payer APIs by January 1, 2027.
- ▶ The Prior Authorization API identifies authorization and documentation requirements and returns payer decisions.
- ▶ Hospital and CAH reporting is optional and bonus-eligible for 2027; CMS has proposed a similar optional measure for MIPS clinicians.

CMS-0057-F • Electronic PA Measure (Medicare / MIPS PI)

TAKEAWAY: The technology changes, but authorization complexity doesn't. EHR readiness matters as much as staffing.

COMING IN 2027



Maryland Expands Behavioral Health Coverage

New coverage mandates open reimbursement pathways

Maryland

EFFECTIVE Medicaid July 1, 2026
Commercial Jan 1, 2027

Expands Collaborative Care Coverage

- ▶ Maryland Medicaid cost-sharing prohibition took effect July 1, 2026.
- ▶ Certain Maryland-regulated insurers, nonprofit plans and HMOs must cover Collaborative Care Model services beginning January 1, 2027.
- ▶ Commercial plans generally cannot impose cost sharing, except for qualifying high-deductible plan requirements.
- ▶ Creates a broader reimbursement opportunity for primary care and hospital-owned physician groups.

MD HB 746 / SB 428 — Chapters 615 / 614

TAKEAWAY: *This pays for behavioral-health integration many practices are already doing informally.*

Maryland

EFFECTIVE January 1, 2027

Expands Perinatal Behavioral Health

- ▶ Carriers and Medicaid must cover perinatal behavioral-health screening at well-child visits (infant's first year)
- ▶ Standing behavioral-health referrals allowed through pregnancy plus one year postpartum, no treatment plan required
- ▶ Affects OB/GYN, pediatrics, primary care, behavioral health, and maternal health programs

MD HB 1118 / SB 891 — Chapters 637 / 636

TAKEAWAY: *Pediatric well-child visits become a new access point for perinatal behavioral health.*