

The logo for SKYGEN, featuring the word "SKYGEN" in a bold, white, sans-serif font. The letter "G" is stylized with a double outline and a horizontal bar extending from its right side. A registered trademark symbol (®) is located at the bottom right of the "N".

SKYGEN®

THE TRUSTED SOLUTION FOR DENTAL & VISION

Regulatory Updates May 2026

AGENDA

- Fee Schedule Updates
- Passed Bills
- To Watch

PASSED: CMS 2027 MEDICARE ADVANTAGE FINAL RULE

- Issued on 4/2/26, effective 6/1/26 (applicable to coverage starting 1/1/27)
- Market: Medicare Advantage
- Summary: The CMS 2027 Final Rule revises the Medicare Advantage (Part C), Medicare Prescription Drug Benefit (Part D), and Medicare Cost Plan regulations across Star Ratings, marketing and communications, drug coverage, enrollment processes, special needs plans, etc.

- **Supplemental Benefits-Debit Card Administration**

- Beginning in 2027, Medicare Advantage plans that choose to use debit cards to administer supplemental benefits must provide cards that are electronically linked to plan-covered benefits through a real-time identification mechanism that verifies eligibility at the point of sale.
- Plans are required to provide instructions to enrollees on how to use the debit card, provide customer support service to enrollees who have questions about how to use the debit card, and maintain an alternative reimbursement process for circumstances where enrollees are not able to use their debit card.
- Debit cards must be limited to the specific plan year — benefits cannot be carried over across plan years.
- Would this impact any of our processes?

- **SSBCI Eligibility Transparency & Objective Criteria (Special Supplemental Benefits for the Chronically Ill)**
 - Plans will need to use objective processes to demonstrate enrollee eligibility and make their SSBCI eligibility criteria publicly available.
 - MA plans must, through health risk assessments, review of claims data, or other similar means, demonstrate that enrollees meet all three criteria: the condition is life threatening or significantly limits overall health or function; the enrollee has a high risk of hospitalization or other adverse health outcomes; and the enrollee requires intensive care coordination.
 - Does SKYGEN administer SSBCI benefits?

- **Elimination of Mid-Year Unused Supplemental Benefit Notices**

- CMS removed an administrative requirement that plans notify enrollees mid-year about unused supplemental benefits.
- Would systems/processes need to be updated to remove any automated mid-year "unused benefit" notification?

- **D-SNP Enrollment Continuity Requirements**

- Beneficiaries can only be passively enrolled into a new D-SNP if that new plan is managed by the same organization as their Medicaid benefits. Beneficiaries must get a minimum of 120 days of continuity of care as they transition to the new plan.
- We would need to support continuity of care for transitioning DSNP members (e.g. provider relationships, ongoing treatment plans, maintaining prior auths)

- **Note Regarding Star Ratings Reforms**

- CMS finalized the removal of 11 Star Ratings measures
- The "diabetes care – eye exam" measure was kept in after the comment period
- Tracks the % of diabetic members who receive an annual retinal or dilated eye exam
- This means that MA plan clients will continue to be measured on diabetic eye exam rates

PASSED: KANSAS MEDICAID/KANCARE UPDATES KS HB 2731

- Passed 4/10/26
- Effective 7/1/26
- **Enhanced Eligibility Verification**
 - KDHE and DCF must perform monthly data matches with other state agencies to verify income, residency, and incarceration status.
- **Deceased Match & Multi-State Checks**
 - Starting Jan 1, 2027, monthly checks (by KDHE and DCF) for deceased individuals and out-of-state Medicaid enrollment are required, allowing for immediate termination of benefits.
- Eligibility and enrollment files will be affected--we may need to process enrollment updates, disenrollments, retroactive adjustments

- **Stricter Application Requirements**
 - Self-attestation for eligibility is prohibited, requiring documentation for income and assets.
 - Anticipate delayed enrollment file receipt, gaps in coverage
- **Reduced Retroactive Medicaid Eligibility**
 - Reduces retroactive Medicaid eligibility from three months to two months.
 - Shortened lookback window for retroactive dental and vision claims.
 - This will likely require updates to processes or systems
- Which departments will be impacted?
- Separate meeting to be scheduled

PASSED: VIRTUAL CREDIT CARD PAYMENT WI SB 367

- Passed 4/3/26
- Effective 4/4/26
- Markets: Commercial
- An insurer that offers a health insurance policy may not require a health care provider to accept payments under the health insurance policy via virtual credit card payment.
- An insurer shall inform a health care provider of the fees associated with any available payment methods and how to select a payment method other than virtual credit card payments before providing a payment via virtual credit card payment.
- If an insurer transmits a payment to a health care provider in accordance with certain federal standards for transmitting electronic funds, the insurer may not charge a fee solely for the transmission, unless the provider has consented to the fee

- Passed 5/5/26
- Effective 1/1/27
- Markets: Commercial, Medicaid, likely MA
- An insurance plan or care management organization may initiate/change payment methods to a provider using electronic funds transfer, including VCC payments, only if:
 - The plan notifies the provider of any associated fees;
 - The plan advises the provider of the available payment methods that does not impose a fee and provides clear selection instructions
 - The provider, through express acceptance, accepts a payment for the claim using a credit card or EFT method
- A provider's selected form of payment remains effective until they choose an alternative method

PASSED: GEORGIA ARTIFICIAL INTELLIGENCE GA SB 444

- Passed 5/5/26
- Effective 1/1/27
- Markets: Commercial, Medicaid, likely MA
- PRAS and UR entities may use AI systems or other software tools, provided that such systems or tools are part of a UR plan that is in accordance with the standards set forth in this chapter
- AI systems may be used to automate tasks, reduce admin burden, participate in decision-making processes, and perform other lawful functions; provided that such systems shall not issue an adverse determination to a patient until a natural person qualifying as a private review agent or UR entity conducts a review in which a clinical peer participates
- AI systems shall not supersede the judgment of a clinical peer

- Passed 4/13/26
- Effective: 90 days after adjournment of general assembly (should be effective mid-August)
- Markets: Commercial, Dental
- Carrier shall not enter into third-party dental network lease agreement unless the participating provider gives affirmative consent
- If the provider consents to the agreement, the carrier shall:
 - Allow the provider the option of contracting directly with the third party
 - Require third party to comply with applicable terms of original contract
 - At the time a contract is entered into or modified:
 - Give the provider a list of all third parties who have or will have access to the services in the contract
 - Allow the provider to remove consent

- Maintain a website through which the provider may obtain a list, reviewed every 90 days, of all third parties that have access to the agreement
- Require a third party to identify on each remittance or explanation of payment sent to the participating provider the source of any contractual discount in rates taken by the third party
- Notify the participating provider at least 30 days before the effective date of a new third-party network lease agreement
- Notify each third party of the termination of a contract at least 30 days before the effective date of the termination
- Make available to the participating provider within 30 days after the provider's request a copy of the contract currently in force that was relied upon by the carrier in the adjudication of the claim

TO WATCH: CREDENTIALING MD HB 1093

- Enrolled 4/9/26, likely going to pass
- Effective 10/1/26
- Markets: Commercial, Medicaid, Dental
- **Shortened credentialing timeline:**
 - Within 5 days (previously 30) after receiving a completed application, the carrier shall send written notice to the provider (at the email address listed in the application, or mailing address if no email is listed) of either the carrier's intent to continue to process the application, or the carrier's rejection of the provider for participation
 - After providing notice of intent to continue processing, the carrier must then accept or reject the provider within 30 days (reduced from the previous 120 days) and send written notice of the acceptance or rejection

- **Credentialing Application Fees Eliminated**

- Repeals the authorization for carriers to charge a reasonable application fee for applications submitted by providers
- Carriers must: allow providers to submit the uniform credentialing form using the online credentialing system; establish a direct telephone number for credentialing inquiries (not the general customer service line); establish a direct email address for credentialing inquiries (not the general customer service email); and respond to voice messages and emails received at those dedicated contact points within 2 business days.

- **Online Credentialing System for Provider Directory**

- A carrier shall use the online credentialing system as the primary source of information to create and update the carrier's provider directory
- The multi-carrier common online provider directory information system must be updated to allow providers to update their information every 120 days or at a frequency established by the Commissioner; grant access to a designated person managing the credentialing process for the provider; and allow providers to access the system directly without the assistance of a third party.

- **Provider Directory Update Timeline for Dental Carriers Accelerated**

- Dental carriers must update provider directory information on the internet within 2 working days after receipt of electronic notification or notification by first-class mail tracking method from a participating provider of a change in the applicable information

- **Provisional Reimbursement Expanded**

- Expands the circumstances under which a carrier must reimburse a group practice at the participating provider rate for covered services provided by a not-yet-credentialed provider.
- Previously, a provider qualified for this provisional payment treatment if they were credentialed by an accredited hospital or had professional liability insurance. The bill adds a third pathway: the provider has immunity under the Federal Tort Claims Act or the Maryland Tort Claims Act (e.g., providers at federally qualified health centers)

- WV SB 729: Introduced 2/3/26
 - Regarding eligibility verification
- OH SB 386: Introduced 3/25/26
 - Medicaid Savings Act
 - Change in how OH administers Medicaid program, shifting from MCO model to ASO model

TO WATCH: RECOUPMENT OH SB 162

- Introduced in House 4/21/26 (about 50% progression)
- A third-party payer shall give a provider a notice of overpayment in writing. If the third-party payer and provider use an agreed-upon established electronic notification system, the third-party payer shall notify the provider electronically through that system.
- Recover period: one year (used to be two years)
- The third-party payer shall give the provider an opportunity to appeal the determination and shall not charge the provider for an appeal
- If the provider fails to respond to the notice within 60 days, the third-party payer may initiate recovery of the overpayment

TO WATCH: PROVIDER PAYMENTS LA SB 465

- Introduced 3/31/26
- No retroactive denial of good faith claims after expiration of 18 months
- Pay claims within 30 calendar days (down from 45 days)
- Notice of pended claim within 2 business days

- Introduced in April/May 2026
- An insurer that offers a health insurance policy may not require a health care provider to accept payments under the health insurance policy via virtual credit card payment.
- An insurer shall inform a health care provider of the fees associated with any available payment methods and how to select a payment method other than virtual credit card payments before providing a payment via virtual credit card payment.
- If an insurer transmits a payment to a health care provider in accordance with certain federal standards for transmitting electronic funds, the insurer may not charge a fee solely for the transmission, unless the provider has consented to the fee