Medicaid and CHIP Payment and Access Commission, December 2025 Public Meeting
December 11, 2025
[Meeting materials available on the MACPAC website here.]
Meeting Summary

On December 11, 2025, the Medicaid and CHIP Payment and Access Commission (MACPAC, or "the Commission") held its December public meeting. HFMA presents a summary of that meeting. Unless specifically attributed to MACPAC commissioners or staff, all forward-looking statements in this summary reflect a prognostication of the Commission's likely actions; such statements are not informed by any proprietary or inside information about MACPAC's future plans.

I. CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN) TRANSITIONS TO ADULT COVERAGE: T-MSIS & INTERVIEW FINDINGS (Linn Jennings and Ava Williams, staff)

ISSUE: Children and youth with special health care needs (CYSHCN) face significant challenges in transitioning to adult coverage. In its June 2025 Report to Congress, MACPAC published findings and recommendations in the first phase of their work examining this issue. A second phase of this work focuses on the transition from child to adult Medicaid coverage, including the age-18 Supplemental Security Income (SSI) redetermination and the transition between child-only and adult section 1915(c) home- and community-based services (HCBS) waivers.

In the September 2025 public meeting, staff provided an overview of CYSHCN-relevant Medicaid eligibility pathways. Roughly half of CYSHCN are covered by Medicaid (or a combination of Medicaid and private insurance), and approximately 15 percent are Medicaid-eligible on the basis of disability. CYSHCN enroll in Medicaid through different mandatory and optional eligibility pathways. These pathways include disability-related pathways, such as SSI-related pathways, and state optional disability pathways, such as a state medically needy pathway, the Tax Equity and Fiscal Responsibility Act state plan pathway, and a state plan HCBS.

PRESENTATION: In the December 2025 public meeting, staff reported on their quantitative analysis of these transitions using data from the Transformed Medicaid Statistical Information System (T-MSIS) and from stakeholder interviews.

T-MSIS. Because there are few reported data on transition-age CYSHCN or their coverage transition outcomes, MACPAC staff examined the experience of Medicaid-covered CYSHCN and their transitions to adult Medicaid coverage using 2017–2019 enrollment data from T-MSIS, focusing on those enrolled in disability-related eligibility pathways. Findings of this analysis showed that the majority of CYSHCN remained continuously enrolled in Medicaid when transitioning to adult Medicaid (82.4 percent), but that percent varied by (i) the disability-related eligibility pathway enrolled in as a child, (ii) beneficiary race and ethnicity, (iii) the beneficiary's

enrollment state, and (iv) state adoption of Medicaid expansion. The adult eligibility pathways that CYSHCN transitioned to differed between those who remained continuously enrolled and those who churned.[1] Specifically, more than 75 percent of CYSHCN continuously enrolled stayed in the same pathway as an adult, but roughly 50 percent of those who churned, enrolled in an adult MAGI pathway. Also, of those who were enrolled in expansion states, 13 percent of those who were continuously enrolled and 48 percent of those who churned were enrolled through the expansion pathway.

Stakeholder Interviews. Information from interviews with stakeholders revealed a variety of factors that affect Medicaid coverage transitions, including the following:

- State eligibility and enrollment systems, such as challenges with ex parte redeterminations for beneficiaries with disabilities and those changing between eligibility groups;
- The outcome of SSI redeterminations and effect on Medicaid eligibility, such as where a beneficiary is not SSI-eligible as an adult, they must be redetermined on all other bases before their Medicaid is terminated;
- Timelines of notices for which no federal requirements exist with respect to how far in advance notices must be sent (some stakeholders believe beneficiaries receive the notices too late);
- Clarity of notices, which some stakeholders believe often lack clear, actionable steps;
- The amount of support beneficiaries receive during the Medicaid and SSI redetermination process, which may vary based on the entity providing support;
- Adult eligibility pathways, with those who remain in SSI as an adult often retaining Medicaid eligibility through an SSI-related pathway; and
- Extended age eligibility for child coverage; staff note that 5 states extended child eligibility for all or a subset of children through a state plan option[2] or a section 1115 demonstration waiver, which may ease the transition process.

Factors were also raised for the success (or lack thereof) of CYSHCN transition to adult coverage under 1915(c) HCBS waivers. Staff found that the thoroughness of state transition planning varies significantly across waivers, and some transition planning may be insufficient to facilitate smooth transitions between waivers. Functional and level of care (LOC) assessments can be burdensome for some beneficiaries with certain conditions; also, assessments take time and beneficiaries may either have not received notice sufficiently in advance or are unaware of the advance planning needed to maintain coverage. Some states use reserve capacity in adult waivers to ease transitions between child-only and adult HCBS waivers, and many states have waitlists, which can lead to gaps in waiver enrollment and impact coverage.

Staff noted the following policy concerns for the commissioners:

- The SSI application process can be challenging and the SSI disability and financial criteria are different for children and adults:

[1] The term "churn" or "churned" refers to the phenomenon of beneficiaries who lose coverage and subsequently re-enroll in the program within a short period of time.
[2] See 42 CFR 435.223.

    - Child disability: functional limitations and abilities of CYSHCN are compared to children without impairments; and
    - Adult disability: the ability to work and perform substantial gainful activity;
- Many adult beneficiaries with disabilities are not eligible for Medicaid through SSI even if they were eligible as children:
    - The disability determination for SSI is different for children and adults, and about half of eligible children remain eligible as an adult; and
    - An individual may meet the disability criteria, but they may not meet the income and asset limits;
- Some young adults who are no longer eligible for SSI as an adult may maintain coverage through other adult Medicaid pathways, such as the adult expansion group;
- Beneficiaries may not receive sufficient support or advance notice with the Medicaid redetermination and waiver transition process, leading to gaps in coverage;
- Some states have implemented policies to reduce beneficiary burden with the Medicaid redetermination, such as providing redetermination notices 30 – 60 days in advance, extending child Medicaid eligibility, and providing case managers;
- Beneficiaries report having difficulty understanding notices from Medicaid and the Social Security Administration (SSA) about how changes to SSI eligibility affect Medicaid eligibility;
- The lack of federal requirements related to Medicaid and SSA coordinating or combining notices related to changes in SSI eligibility and how this affects Medicaid coverage

DISCUSSION: The commissioners agreed that the child-to-adult transition to Medicaid eligibility is extremely complicated given the number of potential pathways, differences in eligibility requirements for children and adults, and the variation in how states carry out requirements under the law and regulations.

1. **T-MSIS Data**

For beneficiaries who were SSI-eligible as a child but lost that eligibility as an adult, Commissioner McFadden questioned whether that change in status is due to an asset issue. Staff noted that the data doesn't help get at the reason for loss of SSI. Commissioner Nardone sought more information on the differences between the SSI-related pathways, along with the types of beneficiaries who could qualify under those pathways. He also noted that the other disability related pathways may apply to many beneficiaries and asked whether, as people churn or move to MAGI, they lose certain benefits or are the coverage benefits the same. Staff will respond to this in January. For beneficiaries who churn in and out of coverage, Commissioner Allen sought more information with respect to those beneficiaries who churned back within 12 months, asking specifically how long were they uninsured whether there were spikes in medical utilization upon their return to coverage. Staff indicated that the average period of time to churn was about 4 months—a little longer for those who moved to MAGI pathways. Commissioner Hartman wanted to know what percentage of beneficiaries qualified through ex parte pathways. Staff didn't look for this specific information, but they did look at differences between under 1634 SSI criteria and 209(b) state pathways and found little variations in continuous enrollment. Commissioner Heaphy sought more data to help determine the causes of churn and what enables those individuals to requalify for coverage. Noting significant differences among states for

maintaining eligibility for this population, Commissioner Killingsworth would like to study the best practices among states with respect to determinations.

2. Interview Findings

Commissioner Snyder was encouraged by the 5 states (DC, MA, ME, FL, and OR) that extended transitions eligibility and wants to learn more from those states about their transition process; she sees this policy as a best practice. Commissioner Killingsworth suggested several potential recommendations, including (i) requiring earlier and repetitive notices using different methodologies; (ii) states should identify a specific entity or entities to ensure parents get the requisite notice and information as well as help navigating the process; (iii) there should be template or sample notices made available for the transition; and (iv) for the section 1115 waivers, there are not specific parameters for transition plans and therefore the Centers for Medicare & Medicaid Services (CMS) should require clear processes for states to help families transition.

Commissioner Ingram wanted to ensure that due considerations are made for tribal members and individuals living in rural communities who may receive care in nontraditional ways. Commissioner McCarthy noted that nonexpansion states have higher percentages of people who do not come back into the program after 12 months and wanted more specific data and data analysis to make state-by-state comparisons. Commissioner Heaphy queried whether CMS could require states to work with SSA to coordinate notices for the transition because there is a need for templates, timelines, and model notices. He also asked whether there is data about the impact of individuals on waiting lists and whether staff could get information on best practices for reducing waiting lists. Staff has spoken to states about waiting lists, and the feedback was that individuals should get on those waiting lists as early as possible before the transition to adult coverage.

On the churn population, Commissioner McFadden sought more details on those who do not return, such as whether they get coverage or not. Staff do not believe the data can show where individuals go when they disenroll, but past analyses show that roughly one to three percent move to the Exchanges. Commissioner Bjork asked whether the data shows that certain state reimbursement methods for navigators or case management activities improve retention of eligibility for these transitions to adulthood. Commissioner Allen notes that in many cases there are many transitions for this population all happening at the same time, such as leaving school and transitioning to adult Medicaid, and wondered whether there is evidence of less churn when one comes off at a later age (i.e., after they have left school). Commissioner Nardone seeks a better understanding of the effectiveness of notices, both with respect to the timing of their delivery and their content. He believes the Commission should be on the record on that issue. He also wants to know whether individuals falling off the program are in the "other disability-related" category and, if so, wants to understand why. He also questioned whether there were other factors that MACPAC should consider in making recommendations.

Public comments included a suggestion to leverage the EPSDT program early to start the transition process; another commenter strongly supported extending child eligibility.

Staff are expected to present potential policy options in the January 2026 MACPAC meeting.

II.A. CONSIDERATIONS FOR IMPLEMENTING COMMUNITY ENGAGEMENT REQUIREMENTS: FINDINGS FROM STAKEHOLDER INTERVIEWS (Janice Llanos-Velazquez and Melinda Becker Roach, staff)

ISSUE: States will soon be required to make Medicaid eligibility for certain applicants and existing beneficiaries contingent on their participation in qualifying community engagement activities in accordance with the 2025 Budget Reconciliation Act. This session revisits the details of the new community engagement requirements and highlights key implementation considerations for states and CMS based on stakeholder interviews, which generally focus on state processes for determining compliance and exceptions, including key questions related to Medicaid IT systems and data availability. States and other stakeholders also highlighted areas where states would benefit from timely federal guidance, technical assistance, and other support. The Commission is interested in plans to monitor community engagement requirement implementation and will have further discussion of that topic at MACPAC's January 2026 public meeting.

PRESENTATION: To identify policy and operational considerations for states and CMS, staff conducted stakeholder interviews during the summer of 2025, which are presented in this session and will be published as a chapter in the March 2026 report to Congress. Staff presented an overview of the community engagement requirements, the mandatory exceptions, the optional short-term hardship exemptions, the timeline for assessing compliance and exceptions, the state-determined look-back period, requirements for use of ex parte processes, and federal funding for implementation. Staff noted that by law CMS must publish an interim final rule (IFR) by June 1, 2026, to implement the community engagement program for 2027. For a detailed summary of these issues, please see HFMA's summary of the September 2025 MACPAC public meeting. Stakeholders provided input on many policy areas, including the following:

1. **Timeline**

CMS must provide as much guidance as it can before the IFR is published in June 2026 in order to help states plan and prioritize more effectively. The agency has acknowledged the amount of work that states must do in a limited timeframe as well as the need for more immediate guidance. For example, states have raised many questions about the criteria and process exceptions and good-faith exemptions. Some states urge CMS to be flexible when granting exemptions and noted that states will be starting from different places.

2. **State Flexibility**

States want CMS to give them maximum flexibility to operationalize community engagement requirements. This is especially important given the short implementation timeline and the variability in state eligibility systems, such as whether those systems are integrated with other human services programs or exchange data with other entities.

3. Beneficiary Outreach

Reflecting on the public health emergency (PHE) unwinding, stakeholders insist that notices be written in clear and plain language and that states must use multiple means of communication to reach targeted individuals, which is a requirement under statute.[3] Other feedback emphasized the importance of conducting outreach in coordination with various partners, including managed care organizations, community health centers, pharmacies, faith-based organizations, and others. Some stakeholders feel that Medicaid Managed Care Organization (MCO) partnerships are most helpful and others encourage the use of multiple communications means, such as using text messaging or other applications, which is also currently a statutory requirement.

4. Mandatory Exceptions

Stakeholders highlighted various data sources for identifying exceptions as well as data limitations (e.g., timeliness) and considerations for accessing data (e.g., cost and need for partnerships with other agencies). The data sources could include the following:

- Medicaid applications (which could be modified to capture relevant information)
- Enrollment data
- Claims data
- Managed care data (including encounter data)

It was noted that State Medicaid programs are less likely to have data on individuals with no prior enrollment relative to existing beneficiaries. Therefore, verification of exception status for applicants will require more information and manual processes.

A common theme was that CMS guidance is needed to clarify criteria for mandatory exceptions and expectations for verification. One stakeholder indicated that they were moving forward with their "best guess" and making changes as needed to align with future CMS guidance.

Other areas of uncertainty include exceptions related to (i) caregiving status, (ii) participation in substance use disorder treatment, (iii) meeting work requirements in SNAP or TANF, (iv) use of self-attestation, (v) medical frailty, and (vi) the frequency of exception status reassessment.

5. Short-Term Hardship Exceptions

States also seek flexibility in considering hardships (e.g., illness and bereavement) that affect an individual's ability to participate in qualifying activities; these concerns are based on their experience with 1115 waivers. Questions were raised about what circumstances will qualify someone for an exception as well as about the type of verification that CMS may require. There is also uncertainty about the lookback period that states will use to calculate the unemployment rate to identify areas where individuals may be eligible for exceptions due to market conditions.

[3] See section 1902(xx)(8)(B) of the Social Security Act.

6. Definition of Community Engagement

States also seek flexibility in defining community engagement criteria. Some stakeholders suggested that states be permitted to assess income over a period of time, such as averaging income over a period of several months.

Further guidance is needed on qualifying community engagement activities, including on the following policy areas:

- The definition of a work program and the inclusion of job search activities.
- How to address supported employment.
- Criteria for activities that qualify as community service; for example, could providing unpaid care to an elderly neighbor qualify?

7. Verifying Participation in Qualifying Activities

It was noted that states that choose to verify compliance more than semiannually could experience increased disenrollment and administrative burden. Stakeholders also observed that working in traditional employment would be least challenging to verify, but nontraditional employment, such as gig work or babysitting, could be extremely challenging.

States will have to use several data sources to support compliance verification on an ex parte basis, and this may involve using existing data sources in new ways and getting data from other state agencies. Stakeholders urge user-friendly solutions for beneficiaries in submitting documentation when it is not possible to use ex parte information.

8. Verifying Employment

Stakeholders discussed the pros and cons of using the Quarterly Wage Data versus Equifax's "The Work Number." Concerns were raised about the cost of "The Work Number," and some feedback suggested that CMS allow states to use "The Work Number" without charge—even on a short-term basis. Others believe CMS's pilot income verification as a service (IVaaS) application could help states address this challenge; however, the application is still being piloted and there is little publicly available information on it.

As noted above, verifying compliance among individuals engaged in nontraditional employment will be very challenging because that data is very difficult to acquire.

9. Verifying Education and Community Service

Verification of education and community service participation also poses challenges. School enrollment data could be used for verifying engagement in education-related activities; however, there are often limitations on how much and under what circumstances that data may be made publicly available. States report that they are working with their state education departments to determine what data can be shared.

Verifying community service will be challenging, but some suggestions were made, including adopting processes used by state agencies for court-mandated community service or allowing beneficiaries to submit documentation.

10. Additional Considerations for Compliance and Exceptions

Stakeholders felt strongly that CMS must allow self-attestation when data are not immediately available to verify their circumstances, and they also urge CMS to provide guidance on viable data sources as well as on expectations for data recency for ex parte verification. States also seek clarification on how they should operationalize the requirement that permits beneficiaries an opportunity to correct verification information in the case of error or more recent data.

11. Medicaid IT Systems

There was universal agreement that Medicaid IT system changes will likely be costly and time-intensive and that the number and scope of system changes will depend on the state's existing Medicaid IT infrastructure. A state's ability to maximize automation is affected by the short implementation timeline and limited funding, and automation could require higher upfront investments compared to manual processes. Additionally, the short implementation timeline limits states' abilities to competitively procure systems vendors.

Stakeholders suggested that CMS support states in the procurement process, including by leveraging the advanced planning document (APD) process to establish expected costs and by streamlining the APD process to expedite processing and ease time and resource constraints.

Feedback also noted that states must assess data they have, the data they need, and the functionality required. Some states felt that they should prioritize low-cost data sources that cover a large share of beneficiaries.

12. Beneficiary Supports

Many stakeholders believe states should support beneficiaries in meeting community engagement requirements, which could include enrollment assisters, enhanced call center capacity, and accessible application locations.

Some interviewees were concerned that states are not required to address barriers to compliance with community engagement requirements, such as lack of transportation. They believe CMS could establish expectations in this area as they did under section 1115 demonstrations.

There was also confusion on whether federal matching funds will be available for beneficiary supports.

13. Monitoring

CMS indicated that it intends to monitor state implementation of the community engagement requirements, and it is using lessons from the COVID-19 PHE unwinding to inform their process.

Stakeholders agree that implementation of community engagement requirements should be monitored because it helps identify trends that may indicate the need for adjustments. For the monitoring to be meaningful, CMS should use timely, high-quality data and establish meaningful metrics. They believe that state reporting during PHE unwinding is a useful model for developing those monitoring metrics.

Some states made additional data from the PHE unwinding publicly available and used those data to identify issues and inform adjustments. Stakeholders suggested new and existing metrics that could help monitor implementation and track beneficiary outcomes after implementation, including the following:

- Existing metrics, especially metrics related to call centers, applications, renewals, and Medicaid enrollment (monthly reports);
- Outcome metrics, including measuring effects on new enrollment, health outcomes, cost of care, and employment rate;
- New metrics that should focus on the population subject to community engagement requirements.

Staff note that most states have not reported on these metrics before, so they must develop these metrics in a short timeframe. Interviewees said information on compliance and reasons for lack of compliance should also be tracked. Additionally, how the reporting should be done is also important; for example, data on beneficiary compliance should be reported by method of compliance.

14. Technical Assistance

States would greatly benefit from multistate, online forums that enable cross-state learning on the implementation of the community engagement requirements across a variety of topics, including beneficiary outreach. Some stakeholders believe that certain CMS approaches during the PHE unwinding are helpful as models.

DISCUSSION: Commissioners were very engaged on this topic, and all were concerned about the scope and timing of the implementation of these new requirements. Many pointed to the PHE unwinding activities as helpful to states in preparing for 2027. For example, some noted the PHE unwinding validates the role of partners to facilitate requirements, such as outreach, enrollment, and verification. Staff were encouraged to study more ways to use partners (such as MCOs) to help here. It was suggested that CMS should provide more guidance on what MCOs can and cannot do. Section 71119(c) of the 2025 Budget Reconciliation Act prohibits states from using Medicaid MCOs or other contractors with direct or indirect financial relationships to MCOs, PIHPs, or PAHPs to determine beneficiary compliance with community engagement requirements. However, there is no other prohibition in the statute on states that elect to delegate some support activities to managed care plans to support states' successful implementation of community engagement requirements.[4]

Commissioner Allen stressed the importance of comparing state policy and state implementation decisions for the community engagement requirements, noting that during the PHE unwinding, CMS provided some flexibilities to mitigate adverse impacts on beneficiaries. The commissioner

[4] Section IX of CMCS Informational Bulletin released on December 8, 2025, essentially reiterates these points.

wondered whether MACPAC should make recommendations to permit similar flexibilities if unexpectedly steep drops in enrollment occur, especially if it varies by state.

Many commissioners agreed that the biggest challenge is information technology (IT) infrastructure and wondered whether states are permitted to use their share of the implementation funding as well as get the usual 90/10 match for IT expenses. Staff noted that CMS recently indicated enhanced matching funds will be available for these costs. Commissioners also wondered what type of flexibilities CMS would allow and whether stakeholders indicated how states are handling this workload beyond IT issues.

Commissioner Ingram raised the issue of beneficiary consent for access to information. She noted issues with receiving information by text or through various applications. If new technologies may be used, will consent be required? She also asked whether the issue of consent came up during interviews. Staff responded that the issue of consent arose with income verification but did not arise in the context of beneficiary outreach or enrollment. The commissioner strongly believes that CMS should provide assistance to help states overcome consent barriers and urged the Commission to make such a recommendation.

Commissioner Nardone believes there should be a framework for effective monitoring and evaluation as was done for the PHE unwinding as well as a method to evaluate the effectiveness of the policy goal of helping individuals find employment and maintain access to healthcare. Commissioner McCarthy sought feedback on possible ways to reach out to individuals who fall off coverage and how to reconnect with them, possibly helping them to get work. He also asked whether any of the current restrictions on MCOs could be reinterpreted in light of this new program. Commissioner Heaphy queried whether states have best practices for reporting this information, noting that it is important to track which populations may not be properly reporting data because of what he referred to as the digital divide. Commissioner Hartman supported ideas that do not put duty of reporting on the individual and noted that unemployment data may not reflect total unemployment.

II.B. EXPERT PANEL ON IMPLEMENTING COMMUNITY ENGAGEMENT REQUIREMENTS (moderated by Janice Llanos-Velazquez and Melinda Becker Roach, staff; panelists were Caprice Knapp, Principal Deputy Director, Center for Medicaid and CHIP Services, and Lindsey Browning, Deputy Executive Director, National Association of Medicaid Directors)

ISSUE: States must implement a community engagement requirement for Medicaid expansion and other low-income adults by January 1, 2027, unless the state receives federal approval for an extended implementation timeline. CMS must publish an IFR by June 1, 2026, and has been and will continue to issue some guidance before the publication of the IFR. Operationalizing these requirements will be a significant undertaking for states, particularly in the relatively short timeline the statute provides for implementation. In this session, panelists discussed areas of concern and described, at a high level, steps taken to date to assist states with their planning.

DISCUSSION: Staff began the discussion by asking panel members a few questions. Then commissioners asked questions and engaged in discussions. Some highlights follow.

Caprice Knapp (CMS):

- CMS has been hearing the same concerns as those reported by MACPAC staff in this meeting.
- The initial concerns were the implementation timeline and IT, but states are now focusing on policy questions.
- Measurement metrics will be a second phase for CMS.
- CMS established an email address for questions on implementation: mailto:MedicaidReforms@cms.hhs.gov.
- CMS emphasized partnerships with states, state Medicaid directors, and other stakeholders.
- CMS acknowledges that June is late for the IFR and more guidance is needed sooner; she noted that CMS released new guidance on December 8, 2025.

Lindsey Browning (National Association of Medicaid Directors (NAMD)

- The major concerns continue to be what is needed for state compliance and what solutions exist as well as the cost of the IT build.
- Another major concern is that eligibility policies, etc., in the bill all come online at the same time, and section 71106 of the 2025 Budget Reconciliation Act ("Payment reduction related to certain erroneous excess payments under Medicaid") limits CMS' ability to use good faith efforts beginning October 1, 2029.
    - This means states must prepare for 2029 and ensure there is a clear paper trail for audit purposes—this was mentioned several times.
- States should be engaging with CMS early and often; this helps in the development of guidance as well as the June 2026 IFR.
- States should be leveraging SNAP (e.g., for integrated applications) and PHE unwinding for engagement.
- More CMS guidance will be needed very soon for issues such as (i) areas where more flexibility will be available, (ii) what a minimum viable product for IT looks like, (iii) a possible glidepath for data feeds, especially for volunteering, (iv) the overlay of other eligibility policies on the basic policies, and (v) the role of MCOs—what is permitted and prohibited in assisting states and beneficiaries.

On the question of lessons learned from the PHE unwinding, Caprice Knapp says the four most applicable lessons from CMS' perspective are (i) to ensure that the state's legislature provides funding for frequent outreach (this was mentioned several times); (ii) how to use existing MCO outreach systems; (iii) vendor engagement, which she says CMS has done, to discuss expectations; and (iv) communication with stakeholders. Lindsey Browning noted that the PHE unwinding was with respect to existing policy and that this is an entirely new program. However, she suggested better automating eligibility processes, such as doing ex parte renewals via linking to other consumer friendly data sources. She also recommended using and improving member engagement structures, such as community partners, to better communicate changes to Medicaid policies. Additionally, states should leverage infrastructure (e.g., text messaging, or maybe AI, and new community partners, such as schools).

With respect to monitoring implementation, the panelists were asked what type of information does CMS already collect and what more it might need. Caprice Knapp says CMS follows up on

the state advance planning documents (APDs); it wants to know the structure in place right now and how ready the state is. A new effort is underway to help states write policies and train staff; CMS meets every month with states to get a sense of their progress. CMS has not made a lot of decisions on measures, but it understands it is a critical part of IT and outcomes measures. Lindsey Browning encouraged CMS to use a reasonable number of measures (based on existing measures) that are built into the IT and said CMS should also monitor what new issues arise, but should not impose too many new reporting requirements.

Commissioner Johnson asked what both panelists were hearing as priorities. Caprice Knapp says CMS hears most often about the minimum viable product for IT. Additional guidance has been requested for qualifying events, exemptions and exceptions, medical frailty criteria, the timeline (which has been described as confusing) and the renewal timeline—the state option on frequency of verification. Lindsey Browing highlighted verification for employment, education, and volunteering.

With respect to the minimum viable product, Caprice Knapp indicated CMS has a readiness review process for both IT and policy development. States and CMS will meet on a monthly basis. Lindsey Browning indicated that Medicaid leaders want to be sure their IT works; they are building in time for testing and staff training. They want better results than in the past, but when a timeline is short, states wrap around IT with manual processes. Commissioner Bjork questioned whether AI will efficiently address so many concerns and whether there would be any prescriptive guidance given to vendors. Caprice Knapp believes it will be an iterative process and did not mention any vendor requirements. Lindsey Browning is skeptical. State Medicaid directors are listening to vendors, noting that there is little experience with AI improvements for eligibility determinations but more areas require testing.

Commissioner McCarthy asked whether CMS is helping states keep IT costs down. Caprice Knapp says CMS has been meeting with vendors to discuss pricing as well as how to establish expectations for a good product and how to build in flexibility for states as part of the basic software. She expects that some states will use their traditional enrollment process vendors and build out codes for these requirements. CMS expects that funding dollars will be separated (for procurement, staff training, and outreach) so the agency can have a sense of what the community engagement costs are. Lindsey Browning believes states might in the future be interested in the CMS pilot application IVaaS; states are concerned not only with the system costs of the initial build but also the ongoing costs of accessing data from sources.

Commissioner Ingram raised her issue of consent for accessing employment and other information with the panelists. Neither panelist indicated that much thought was given to this issue, and they stated that states have not raised the issue. Caprice Knapp noted that consent is not needed for Equifax's "The Work Product" database and that it was unlikely that the IFR would address the issue.

Commissioner Allen asked whether the agency felt it could pause requirements if there are indications of serious problems, such as a precipitous drop in enrollment. Caprice Knapp said CMS was working on a hold harmless policy for a certain period of time, but this is intended only for those states that elect to implement community engagement requirements early (i.e.,

before 2027). She believes CMS could implement a pause policy for other states. In response to another question, Lindsey Browning believes MACPAC could provide help with measuring outcomes—specifically what a small set of measures might look like. Similarly, assistance could be provided with beneficiary outreach, such as how to articulate and communicate to individuals who are impacted; she believes a list of best practices would be helpful.

Commissioner Nardone raised the issue of a timeline for monitoring metrics, which CMS indicates is not on their priority list at this time.

After the expert panel sessions, commissioners highlighted their major areas of concern to inform their work going forward. Seeing similar issues with other large program change implementations, there is concern with multiple implementation dates and the vast array of complicated policy decisions. Concern was also expressed over the limitations on the ability of states to use waivers to avoid penalties, and MACPAC should think about what states can do to mitigate risk. Additionally, states must develop and implement documentation protocols since this is the first time they will be incorporating community engagement requirements into their eligibility and enrollment protocols. Others believe MACPAC should monitor implementation differences among states and catalog the impacts of policy decisions at the state level. Commissioners generally supported the concept that MACPAC could come up with a recommended set of metrics and measures, but they noted that it is a little late in the process for such an effort. MACPAC should also study how MCOs could be leveraged for outreach and other activities, including possibly in assisting with finding employment for beneficiaries. Concern was raised about the cost to use the Equifax database.[5]

III. STATE AND FEDERAL TOOLS FOR ENSURING ACCOUNTABILITY OF MEDICAID MANAGED CARE ORGANIZATIONS: INTERVIEW FINDINGS

ISSUE: Managed care is the predominant health care delivery system in Medicaid; therefore, oversight of Medicaid managed care programs is a priority. This session focused on the use of managed care accountability tools and the findings staff made after 18 stakeholder interviews conducted during the six-month period beginning December 2024. Stakeholder groups included State Medicaid agency officials, MCO representatives, Medicaid health plan trade associations, relevant federal agencies, and national experts and organizations.

PRESENTATION: Staff provided the background and federal requirements for oversight and then described themes from stakeholder interviews across three key areas: procurement and contract requirements, use of state and federal accountability tools, and CMS oversight and guidance. Additionally, staff supplemented the interview findings with an analysis of Managed Care Program Annual Reports (MCPARs), which are available through CMS.

1. Interview Findings

Procurement and Contract Requirements. Stakeholders noted that the procurement process is an early opportunity for states to identify high-performing plans and establish performance

[5] See https://www.nytimes.com/2025/11/03/health/medicaid-cuts-equifax-data.html?unlocked_article_code=1.yU8.JL5p.nP5JjQ56N-8I&smid=url-share

expectations, and that they use past performance as part of the bid evaluation to identify patterns of contract violations and screen for poor performance. Some state procurement rules limit the use of MCOs' past performance or forbid the use of publicly available information from other states to validate MCO self-reports.

Past performance is sometimes used to inform monitoring of plans, such as proactively monitoring for service denials or other potential utilization management issues.

Use of Accountability Tools. States often address plan performance or plan policy issues through informal channels with MCOs, such as regular monthly meetings, before escalating to formal sanctions. States vary the use of accountability tools (corrective action plans (CAPs), monetary penalties, enrollment sanctions, etc.) based on the severity and duration of the contract violation or performance issue.

The six states that were interviewed set thresholds that automatically impose a serious penalty, such as a fine or enrollment suspension, for violations or performance issues that have immediate consequences for enrollees. They varied in how and when they impose formal sanctions, and some did not have documented criteria and policies as to what triggers escalation.

Stakeholders generally preferred incentives over penalties to motivate changes in MCO performance and behavior. Accountability tools include bonus payments, auto-assignment, and capitation withholds to foster competition and motivate MCOs to achieve improvement targets.

When monetary penalties are imposed, they are often small compared to the level of capitation payments. States can use sanctions, but they can be more challenging to administer because MCOs (i) regularly appeal enforcement actions or (ii) contact the state legislature or governor's office to obtain relief from sanctions.

Stakeholders find that publicly reporting CAPs and other sanctions is an accountability tool that promotes transparency. Four of the interviewed states post CAPs and monetary penalties on state websites; the other two publish quality measure performance only.

CMS Oversight and Guidance. CMS has broad authority to ensure that State Medicaid managed care programs are structured to be compliant with federal requirements, but it has fewer tools to directly address specific MCO deficiencies. For example, CMS can defer federal matching funds but only for the entire amount of the capitation payment made to the plan. This is a draconian option and thus is rarely used because it disrupts beneficiary financing for all enrollees for the whole benefit package under the plan.

CMS does not have the same array of oversight tools that are available in fee for service, such as imposing formal CAPs on states or deferring a share of the federal match for capitation payments in proportion to the severity of non-compliance.

Some stakeholders believe CMS could provide states with additional guidance and resources on effective procurement practices and sanction policies. CMS could also develop a national publicly available database of MCO contract violations and sanctions.

2. Managed Care Program Annual Reports (MCPARs)

States must post MCPARs on their state Medicaid website, and CMS posts MCPARs from states in a central repository on Medicaid.gov. Among the topics included in MCPARs, information is available on grievances, appeals, state fair hearings, sanctions and corrective action plans. MACPAC analysis focused on the types of sanctions, the amount of financial penalties, the reported reasons for the intervention, and the time to remediation. Staff made the following findings.

States are more likely to take intermediate steps before escalating to monetary penalties. For example, the reports reveal 359 CAPs sanctions from 25 states, 19 CAPs and liquidated damages from 2 states, 106 civil monetary penalty sanctions from 11 states, 187 liquidated damages sanctions from 10 states, and 66 compliance letter sanctions from 8 states. Only 12 of 359 CAPs (3.3 percent) had an associated financial penalty. While the amount of financial sanctions imposed can vary, the most common value reported was less than $5,000. Average sanction amounts vary by intervention topic, with sanctions related to beneficiary rights and communications proving the least costly for MCOs. Most of the reported sanctions (54.8 percent) were remediated within 90 days, and only 3 percent took longer than 360 days to resolve.

MACPAC staff believe states are not likely reporting all sanctions in their MCPAR reports; this is based on the omission of a significant amount of data as well as the fact that these are relatively new reports.

3. Key Findings

Stakeholder interviews show that states generally have adequate tools through sanctions and incentives to oversee MCO performance and that most states take an incremental approach and use regular check-ins to identify and address performance issues before issuing formal sanctions. Incentives and sanctions that have a substantial impact on plan revenue are more effective.

Public reporting of MCO performance, such as information on frequency and type of sanctions, could be a useful tool for oversight and future procurement decisions. CMS could create toolkits or other guidance to help states design more effective procurement processes or sanction policies.

Federal officials and national experts noted that CMS does not have the same authority to oversee and address issues in managed care that they do in the fee-for-service program, and they were interested in equalizing the tools across delivery systems.

Commissioner Bjork was interested in the gaps in reporting. Staff believe the issue may in part be tied to definitions of terms; for example, liquidated damages are not reported. There are also timing issues due to states awaiting the final outcome of applicable grievance and appeals processes. Staff also noted that it is difficult to find this information on plan websites. The commissioner would like a pathway to achieve commonality of definitions, which is a policy that Commissioner Nardone supports.

Commissioners had different positions on whether CMS should be granted more sanction authority, such as the ability to impose federal intermediate sanctions. Some believe this would be workable if tied to a specific problem; most agreed withholding all payments is not good policy. Commissioner Killingsworth believes that using CAPs more frequently than financial penalties is a good thing. She was interested in knowing more about how CMS uses its sanctions authority under the fee-for-service program and believes states and not the federal government should deal with MCOs.

Commissioners also had differing views on whether to use past plan performance in making contracting decisions. Some believe that the plan's past performance in the state in question was important and others would extend that to the plan's performance in other states, arguing for more information and transparency in the contracting process. Another viewpoint was that there was no need to require past performance in making state procurement decisions.

Commissioner Hartman believes states should engage with providers and get their perspective on access under the plan when deciding whether to award a contract. Staff noted that some states believe it would be helpful to have guidance on an appeals process.

Staff may present policy options at a future meeting.

NOTE: Transcripts and presentation slides are generally available three to five days after the meeting on MACPAC's website.