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MACPAC Holds April 2026 Meeting

On April 9 and 10, 2026, the Medicaid and CHIP Payment and Access Commission (MACPAC) held a public meeting, which included the following sessions:

- Implementing Community Engagement Requirements in Medicaid;
- State and Federal Tools for Ensuring Accountability of Medicaid Managed Care Plans: Draft Chapter;
- Automation in Medicaid Prior Authorization: Draft Recommendations;
- Exploring the Role of the State Medicaid Agency in the Program of All Inclusive Care for the Elderly: Policy Options;
- Pharmacy Benefit Managers and Medicaid;
- Introduction to Medicaid Program Integrity; and
- Intensive Community-Based Behavioral Health Services: Findings from Federal and State Policy Review.

The full meeting agenda and session presentations are available here.

IMPLEMENTING MEDICAID COMMUNITY ENGAGEMENT REQUIREMENTS: DRAFT RECOMMENDATIONS

In this session, MACPAC staff presented on the implementation of community engagement (CE) requirements in Medicaid, identifying critical policy and operational considerations for states and CMS. Prior to recent changes in federal law, some states pursued Section 1115 demonstration projects to implement work and CE requirements, while CMS approved 13 demonstration projects between 2018 and 2020. Most tests were not fully implemented, and where implementation occurred, observed and projected coverage losses were substantial, and administrative costs were significant. Staff found coverage losses and compliance failures among beneficiaries attributable to a lack of beneficiary awareness, pervasive barriers to employment, and significant administrative costs in some states.

CE requirements, as detailed in the 2025 Budget Reconciliation Act, include work and volunteering requirements and apply to non-pregnant, non-dually eligible individuals

aged 19 to 64 who were eligible for the adult expansion group (or a Section 1115 waiver). Beneficiaries must work 80 hours in a given month, or maintain a minimum of half-time school enrollment. Apart from potential Section 1115 waivers, these requirements are subject to states' discretion of mandatory and voluntary exceptions.

MACPAC provided four guiding principles for CMS to facilitate the implementation of CE requirements:

- **CMS should provide timely federal guidance and technical assistance to states:** Early engagement with states by CMS is critical, given the tight timeline, because states could benefit from CMS guidance before interim final rule publication. Interviewees noted that guidance is needed on good-faith effort exemptions, medical frailty, and self-attestation. CMS issued preliminary guidance in December 2025 and has been engaging with states through state-only forums and providing support with information technology solutions.

- **CMS should work with states to ensure eligible individuals can gain and maintain coverage:** Stakeholders emphasized concerns about the tendency of the ex parte process to minimize beneficiary reporting, leading to coverage losses. To remedy this, MACPAC suggested that states modify existing data (e.g., income, Medicaid applications, or claims), add data sources, and automate data checks to assess compliance. Lack of timely data creates a gap in oversight and can be challenging and expensive. Self-attestation may fill gaps where data is limited. Coordination with managed care organizations and other partners would also be a key mitigating factor, along with monitoring to identify and address issues.

- **CMS should prioritize efficiency when managing Medicaid IT systems:** Medicaid IT system changes will likely require a greater initial investment, and be costly and time-intensive, but could reduce the workload and resources needed to train case workers. Short implementation timelines also limit states' ability to automate processes and competitively procure vendors. CMS is encouraging participation in the General Services Administration timeline to streamline procurement.

- **CMS and states should use timely monitoring and evaluation data to inform policy and operations:** Stakeholders emphasize the importance of monitoring to identify and address issues that may contribute to coverage loss. CMS regularly uses state-reported data to support monitoring and oversight. Several stakeholders noted the need to evaluate if CE requirements were meeting the goals of improving health and increasing employment, given expected administrative costs.

Draft Recommendations

Recommendation 1:

"The Secretary of the U.S. Department of Health and Human Services should direct [CMS] to develop a transparent plan for monitoring and evaluating community engagement requirements in Medicaid that provides insight into how such policies affect eligibility and enrollment, health status, employment, state and federal administrative spending, and the attainment of other identified policy goals. CMS should identify new metrics for state reporting, as needed, and build upon existing data collection activities to minimize administrative burden. Additionally, CMS should ensure timely publication of monitoring and evaluation results to inform policy and operational decision making."

MACPAC's research underscores the need to monitor eligibility and enrollment changes following the implementation of the CE requirement. While CMS's monitoring plans are in development, it is unclear if those plans or the resulting state reporting will be public. MACPAC also noted that CMS should consider ways to minimize state burden and make data publicly available monthly. The importance of evaluation at the state level, and by CMS, was also emphasized. input and make the results public. In addition to a full-scale evaluation, rapid-cycle evaluation reports could provide timely, actionable insights to support continuous improvement.

MACPAC's anticipated implications for the draft recommendation include:

- **States:** Additional reporting would be required, which could also support states' own monitoring and program improvement.
- **Enrollees:** No direct effect, but the draft recommendation could help reduce coverage barriers for eligible individuals.
- **Federal:** An estimate is needed from the Congressional Budget Office.
- **Plans and providers:** No direct effect.

Commissioner Discussion

Some commissioners recommended expanding the dialogue surrounding evaluation and monitoring, while others sought potential modifications to the draft recommendation language. In terms of monitoring and evaluation, several commissioners asserted the need for distinction between the two concepts and the roles of federal and state entities in each. They simultaneously acknowledged the states' capacity to monitor CE implementation and underscored their limitations for effective evaluation, a responsibility they noted was better suited for CMS. Commissioners thought it particularly critical for CMS to track the health of those who had disenrolled from the program. Recommendations will be voted on in May.

STATE AND FEDERAL TOOLS MEDICAID MANAGED CARE PLAN ACCOUNTABILITY: DRAFT CHAPTER

In this session, MACPAC staff provided an overview of existing state and federal tools for comprehensive oversight of Medicaid managed care plans. Managed care, which is the predominant delivery system in Medicaid, tends to have siloed performance data across reporting systems, worsening its capacity for access and comparison. States report managed care programs via the Managed Care Program Annual Report (MCPAR), which is characterized as inconsistent and incomplete, with limited usability. Staffers indicated that MCPAR reporting undercounts the actual use of accountability actions, with state variations reflecting its unclear definitions. CMS has broad authority to oversee state managed care programs, but limited tools to address specific deficiencies. Given these challenges, the following recommendations were proposed:

Recommendation 3.1:

"The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to provide guidance on how to consistently report the types of accountability actions, such as liquidated damages, informal interventions, and other accountability actions, such as liquidated damages, informal interventions, and other accountability actions, taken in response to planned noncompliance in the sanctioned section of the Manage Care Program Annual Report (MCPAR) pursuant to 42 CFR, 438.66(e)(2)(viii)."

This option builds upon MACPAC's March 2024 recommendation on MCPAR data quality for denials and appeals. The proposed recommendation would provide guidance on which types of accountability actions should be reported and how to report them consistently.

MACPAC's anticipated implications for the draft recommendation include:

- **Federal:** No estimated change according to the Congressional Budget Office (CBO).
- **States:** Minimal burden focused on how to report data already being collected. Some states may need to adjust internal tracking systems to ensure consistent information processing.
- **Enrollees:** Improved transparency on how states hold plans accountable for performance.
- **Plans:** No direct burden; states ' requests for additional documentation may impose some burden indirectly.

- **Providers:** Publicly accessible plan performance information may beneficially inform contracting decisions.

Recommendation 3.2:

"The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to develop a publicly available database on managed care plan performance that links federally mandated reported data together to facilitate analysis. CMS should also issue guidance and toolkits to help states effectively use these data to assess past performance, improve beneficiary experience, and oversee managed care plans."

This option would build upon MACPAC's March 2025 recommendation on external quality review. The proposed recommendations aim to enable states to better use existing data rather than report new data, with the goal of improved access to care.

MACPAC's anticipated implications for the draft recommendation include:

- **Federal:** No estimated change according to CBO.
- **States:** Would be provided with better information on plan performance.
- **Enrollees:** Will have the ability to assess plan performance and make informed decisions during plan selection.
- **Plans:** No direct burden; combined data provides a more complete picture of performance.
- **Providers:** Will benefit from completely publicly accessible plan performance information to inform contracting decisions.

Commissioner Discussion

The Commission discussion primarily addressed the existing measures for state reporting. One suggested that the inadequacies of state reporting were overstated in the presentation and that many states had robust systems in place to manage data. While many commissioners concurred, some thought it important to recognize the challenges associated with state variance, arguing that the federal perspective of data might be more difficult and less opaque than the states' view. There was consensus on the need for a publicly accessible database, and some commissioners cautioned against adding administrative burden on the states. Commissioners also sought changes to the first recommendation, proposing the insertion of specific language on the consistency of reporting.

The Chair Commissioner reemphasized the need for these alterations to the draft and applauded the discourse on data fragmentation. In a subsequent session, all 17 commissioners voted in favor of both recommendations. The Commission will finalize a chapter for the June report to Congress, and MACPAC will continue to examine Medicaid managed care oversight and accountability.

AUTOMATION IN THE PRIOR AUTHORIZATION PROCESS: DRAFT RECOMMENDATIONS

In this session, MACPAC examined the use of automation in Medicaid prior authorization (PA) processes, including how states and managed care plans are using automated tools to review requests, apply coverage criteria, and make authorization decisions.

MACPAC staff highlight that states and managed care plans are increasingly using artificial intelligence (AI) and algorithmic tools in the Medicaid PA process. Both states and the federal government have limited visibility into how managed care plans deploy automation, including how decisions are made and the resulting approval or denial rates, pointing to gaps in transparency and oversight. Current federal policy neither explicitly prescribes nor prohibits the use of automation in PA, and while some states have enacted legislation and established AI governance structures, approaches remain inconsistent.

This fragmented regulatory environment, combined with limited federal guidance, has slowed adoption, as stakeholders weigh the potential for clearer standards against concerns about restricting innovation. Additionally, automated PA systems pose risks, including the potential for incorrect decisions, algorithmic bias, and increased adverse determinations, all of which may be difficult to detect due to the complexity and opacity of these tools. These challenges underscore the need for greater transparency, clearer guidance, and more consistent oversight to ensure automation supports access to care. MACPAC staff outline several policy principles for the use of automation in Medicaid PA, emphasizing that these technologies can create administrative efficiencies for payers and providers, thereby improving the timeliness of approvals, beneficiary experience, and access to care. Transparency and disclosure are critical for documenting and assessing how automation is used, particularly in identifying emerging risks.

MAPCAC presented four draft recommendations that would improve oversight of PA processes in Medicaid FFS, reducing the risk of automated systems independently issuing incorrect adverse decisions; provide clarity regarding federal requirements; and create consistency across FFS and managed care. Stakeholders agree that a human in the loop is required as an appropriate safeguard.

Draft Recommendations

Draft Recommendation 1

"[CMS] should issue guidance to state Medicaid agencies and Medicaid managed care plans clarifying that the language at 42 CFR 438.210(b)(3) requires an individual with appropriate expertise to review and authorize all decisions to deny service authorizations, including those proposed by automated systems.

This guidance should clarify further that (1) adverse determinations may not be made by automation tools alone; (2) adverse determinations must be made based on determinations of individual medical necessity; and (3) all existing regulatory requirements related to adverse determinations apply whether or not automation is used in the process of issuing an authorization decision."

MACPAC's anticipated implications for various stakeholders include:

- **Federal:** An estimate from CBO is needed.
- **States:** Will benefit from additional transparency and disclosure; may also have minimal additional administrative costs.
- **Enrollees:** Benefit from clear oversight of PA decisions.
- **Plans:** Minimal marginal impact on PA operations due to existing requirements.
- **Providers:** Minimal direct impact but may experience downstream impacts due to of changes in PA process.

Draft Recommendation 2

"The Secretary of the U.S. Department of Health and Human Services should direct [CMS] to amend the regulations at 42 CFR 440.230 to provide that, in fee-for-service Medicaid programs, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs."

MACPAC's anticipated implications for various stakeholders include:

- **Federal:** An estimate from CBO is needed.
- **States:** Minimal additional administrative costs.
- **Enrollees:** Benefit from clear oversight of PA decisions.

- **Plans:** No impact.
- **Providers:** Minimal direct burden, but PA process changes may result in downstream impacts.

Draft Recommendation 3

"The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance to state Medicaid agencies and Medicaid managed care plans specifying ways in which existing regulatory oversight processes, including the external quality review process and mandated plan reporting required for Managed Care Program Annual Reports, can be used to create effective oversight of managed care plans' use of automation in utilization management (42 CFR 438.66, 42 CFR 438.350 and 42 CFR 438.66(e)(1))."

MACPAC's anticipated implications for various stakeholders include:

- **Federal:** An estimate from CBO is needed.
- **States:** Improved ability to maintain flexibility about how oversight mechanisms are implemented; benefit from additional federal guidance and technical direction.
- **Enrollees:** No direct impact but may benefit from clear oversight of PA decisions.
- **Plans:** Increased administrative costs and new reporting or oversight requirements where new processes are implemented.
- **Providers:** Minimal direct burden, but PA process changes may result in downstream impacts.

Draft Recommendation 4

"State Medicaid agencies should amend their Medicaid managed care plan contracts, on a timeline that is practicable, to require disclosure or other reporting of the use of automation in plans' coverage and authorization processes described at 42 CFR 438.210. Disclosure should facilitate state visibility into the applications of automation tools and other meaningful elements of automation, such as plans' protocols for testing, evaluation, and oversight. To the extent possible, states should modify existing reporting requirements or existing oversight processes to minimize additional administrative burden."

MACPAC's anticipated implications for various stakeholders include:

- **Federal:** An estimate from CBO is needed.

- **States:** Increased transparency may be beneficial, but there may also be minimal increased administrative costs.
- **Enrollees:** No direct impact but may benefit from clear oversight of PA decisions.
- **Plans:** May have increased disclosure and adoption requirements.
- **Providers:** Minimal direct burden, but PA process changes may result in downstream impacts.

Commissioner Discussion

Commissioners generally expressed support for the draft recommendations, describing them as thoughtful and appropriately balanced in addressing the growing role of AI and automation in prior authorization. Several commissioners emphasized the importance of maintaining review by individuals with appropriate expertise, particularly for adverse determinations. However, the discussion highlighted the need for greater clarity on how early and consistently human expertise should be integrated into the process to avoid unnecessary delays or administrative burden.

A significant portion of the discussion focused on defining and operationalizing adverse determinations. Commissioners raised questions about whether partial approvals, substitutions (e.g., generic versus brand drugs), or administrative denials should be treated the same as full denials, and suggested clarifying that recommendations apply primarily to medical necessity decisions for covered benefits. There was also concern that requiring human review for all denials, including those clearly outside benefit coverage, could create inefficiencies.

Commissioners underscored the importance of clear, actionable communication in denial notices. Several noted that lack of explanation for adverse decisions creates burden for providers and beneficiaries, often requiring time-consuming follow-up. Suggestions included aligning with existing standards (e.g., plain language requirements and accreditation guidelines) and ensuring that denial rationales are transparent and accessible.

The role and qualifications of the reviewing individual were also emphasized. Commissioners supported specifying that reviewers should have relevant clinical or subject-matter expertise, noting that credentialed decision-making carries accountability and is critical for appropriate oversight of automated processes. Additional discussion addressed practical and technical considerations, including whether human reviewers should have access to underlying algorithmic or proprietary information, and how to ensure fair and independent review. Commissioners also raised concerns about variability across service types (e.g., pharmacy versus other

services), suggesting that recommendations may need to better be distinguished between different utilization management contexts.

Several commissioners highlighted the importance of aligning Medicaid policy with existing Medicare frameworks to reduce fragmentation and encouraged tying recommendations more explicitly to broader principles such as transparency, flexibility, and responsible adoption of AI. There was also recognition that while automation can improve efficiency, particularly for approvals, its value should be evaluated in terms of both speed and overall impact on beneficiaries and providers.

ROLE OF MEDICAID AGENCIES IN THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY: POLICY OPTIONS

In this session, MACPAC staff presented how states define and implement oversight of the Program of All-Inclusive Care for the Elderly (PACE) and identified gaps and areas of overlap with federal oversight efforts based on stakeholder interviews.

Interview questions posed to stakeholders focused on their interpretations of oversight and on how states monitor PACE quality and performance while navigating ambiguity in the federal–state division of oversight responsibilities. Staff found that interviewees generally acknowledged that states have the legal authority to oversee the PACE, though the interpretation and implementation of statutory oversight functions varied across states. Some officials described a narrower role that emphasizes collaboration with CMS, while others reported taking a broader, more proactive approach to oversight.

States rely on a combination of federal mechanisms and state-developed tools to monitor PACE organizations. These tools include audits, policy letters, provider manuals, regulations, licensing requirements, and clinical coverage policies, along with data submitted through CMS's Health Plan Management System (HPMS) on enrollment, incidents, grievances, and quality indicators. Although PACE organizations report operational and quality data, such as falls, immunizations, and emergency department visits, there are no standardized national quality measures, and the data are not publicly released. Some states supplement these requirements with additional reporting, including participant satisfaction surveys commonly conducted using the Integrated Satisfaction Measurement for PACE (I-SAT) tool.

Several interviewees also highlighted limitations affecting oversight capacity. Some states cited resource constraints and the absence of standardized quality metrics as barriers to evaluating PACE performance, while others noted challenges coordinating oversight activities with federal partners. States with larger or expanding PACE programs reported greater pressure on oversight resources, and stakeholders

frequently emphasized the need for greater national standardization of quality measurement to strengthen oversight and performance evaluation across programs.

Policy Options

Policy Option 1

"The Secretary of the U.S. Department of Health and Human Services (HHS) should direct the CMS to update audit protocols and three-way program agreements to facilitate joint audits of PACE organizations with state administering agencies. Audit coordination should include joint planning of audit scopes, sharing documentation requests, and reviewing evidence concurrently, while preserving CMS's responsibility for assessing federal requirements and states' responsibility for assessing state-specific requirements."

This policy option aims to enable concurrent review of overlapping requirements to reduce duplication and burden, while improving visibility through shared insights and alignment of findings where appropriate.

MACPAC's anticipated implications include:

- **Federal:** An estimate from CBO is needed.
- **States:** Reduced duplication and better access to federal audit findings.
- **PACE organizations:** Reduced administrative burden from multiple oversight reviews.
- **Enrollees:** Improved service quality and care due to stronger oversight.

Policy Option 2

"The Secretary of the U.S. Department of HHS should direct the CMS to aggregate and publicly release, in a user-friendly format on the CMS website, existing PACE program performance data, including data PACE organizations submit through the CMS Health Plan Management System (HPMS) as well as enrollee satisfaction data collected as part of PACE organization quality improvement programs pursuant to 42 CFR 460.134(a)(2)."

This policy option would make PACE performance data public by publishing existing data reported to CMS on the CMS website; it does not require new data collection from PACE organizations. CMS should also aggregate and report data already collected (HPMS metrics, Integrated Satisfaction Measurement for PACE (I-SAT) survey results, audit results). This policy option ultimately enhances transparency for beneficiaries, enabling them to compare PACE with other LTSS, and strengthens evaluation.

MACPAC's anticipated implications include:

- **Federal:** An estimate from the CBO is needed.
- **States:** Clearer picture of performance trends, enabling comparisons across programs within their jurisdiction.
- **PACE organizations:** Minimal additional reporting burden; provides a way to demonstrate program performance.
- **Enrollees:** Improved understanding of services offered and a clearer comparison of PACE and LTSS options.

Policy Option 3

"The Secretary of the U.S. Department of HHS should direct the CMS to amend regulations at 42 CFR 460 Subpart H to develop a standardized, national quality measure set for PACE organizations. Quality data should be compiled and made publicly available in an accessible format."

This policy option would establish new standards for the PACE quality measurement framework, with a publicly available data scorecard on key outcomes and enrollee satisfaction measures. Suggested formats or presentations include the Medicare Advantage Star Ratings or the Medicaid Core Set dashboard.

MACPAC's anticipated implications include:

- **Federal:** An estimate from CBO is needed.
- **States:** Decreased burden and effort duplication.
- **PACE organizations:** Initial burden as organizations adjust to new reporting.
- **Enrollees:** Improved transparency and opportunities for comparison between PACE and other programs.

Commissioner Discussion

Commissioner discussion focused on the disconnect between state and federal oversight of the PACE program and the lack of national, standardized assessment metrics. One commissioner questioned the state's use of the two-way interpretation, while another was concerned about the lack of transparency and accountability within the PACE program, especially when compared to other care models. In response to the latter concern, a commissioner countered with examples and testimonials highlighting the PACE program's strengths, despite the need for more data and standardized performance metrics. Addressing the two-way interpretation, staffers noted a positive perception among states that have used it, explaining that it enabled simultaneous

state oversight and the issuance of provider guidance, and that it may serve as a model for other states.

Overall, commissioners reached consensus on the need for more data on the PACE program, less fragmentation of state oversight efforts, and standardized metrics for program assessment. The Chair Commissioner reiterated these needs, emphasizing increased state capacity, improved quality measurement standards, and external coordination among states and federal officials. There were no draft recommendations, though staff noted they would present a draft chapter in May and potentially vote on recommending the policy options.

PHARMACY BENEFIT MANAGERS IN MEDICAID

In this session, MACPAC examined the current state of Pharmacy Benefit Managers (PBMs) within the Medicaid program.

The Medicaid Drug Rebate Program (MDRP) requires drug manufacturers to provide rebates for their products to be eligible for federal matching funds under Section 1927 of the Social Security Act. While states must generally cover these products, they can manage utilization through tools like Preferred Drug Lists (PDLs) and prior authorization. Federal rebates are calculated using statutorily defined formulas, and MDRP requires payment of pharmacy ingredient costs at actual acquisition cost (AAC) plus a dispensing fee under fee-for-service (FFS). PBMs provide a range of administrative and clinical services to help payers administer the prescription drug benefit and have a central role in the drug distribution chain.

PBMs' common administrative services include processing claims and payments, establishing a network of participating pharmacies, and negotiating drug rebates and discounts with drug manufacturers. PBMs provided utilization management and drug utilization reviews to 28 states as of July 2023. They also handled claims processing and/or payment for 26 states and rebate administration for 24 states, which involves negotiating supplemental rebates. Common PBM clinical services include developing a formulary/PDL to manage provider and beneficiary use, developing tools and strategies to manage covered medications, managing pharmacy and therapeutic (P&T) committees to develop coverage policies, and monitoring patterns of drug misuse through utilization reviews.

Revenue is mostly generated through spread pricing, where the PBM keeps the difference between what it charges the payer and what it pays the pharmacy, along with administrative fees and a portion of manufacturer rebates (an estimated 90 to 95 percent of rebates are passed on to the plan sponsor). However, these financial and operational structures vary significantly between models: FFS typically utilizes transparent "actual acquisition cost" (AAC) payments and single statewide PDLs,

whereas managed care organization (MCO) models are more likely to involve negotiated rates, spread pricing, and plan-specific formularies. Spread pricing is a major concern, as PBMs charge payers more than they pay pharmacies, keeping the difference as revenue. Spread pricing lacks transparency into how much revenue PBMs generate and creates incentives for PBMs to lower payments below a pharmacy's costs. While regulatory standards in FFS settings limit this, it remains more prevalent in MCOs where PBMs negotiate payment terms. Some states have published studies showing that the prices PBMs charge in MCOs were often higher than those in FFS. A switch to pass-through pricing may not reduce overall drug spending.

In addition to spread pricing, other concerns include PDLs, formularies, rebates, and pharmacy networks. There are ongoing concerns about patient steering, in which PBMs may direct beneficiaries to PBM-owned or affiliated pharmacies to increase revenue. With PDLs, formularies, and rebates, PBMs have an incentive to prioritize drugs with higher rebates over those with the lowest cost, potentially increasing beneficiary cost-sharing and incentivizing higher list prices. Rebate retention is likely to be less of a concern for Medicaid because many rebates are statutorily defined in the MDRP and paid directly to states. 14 states allow plans to negotiate their own rebates, and 10 of the 14 require the plan's PBM to pass through all rebates to the plan. Additionally, multiple Medicaid plan formularies can create administrative complexity for the state and beneficiaries. Furthermore, limited pharmacy networks can lower costs for plans and enrollees, but can create access issues.

Current federal policy remains limited regarding PBM regulation in Medicaid; however, states have taken more expansive action. The Consolidated Appropriations Act of 2026 (CAA 2026) introduced PBM requirements for Medicare and commercial markets, such as rebate pass-through provisions, but did not include Medicaid-specific reforms due to cost-scoring constraints. At the state level, all 50 states have enacted some form of PBM legislation. Common provisions include prohibiting gag clauses (45 states), limiting beneficiary cost-sharing in 37 states, and requiring PBM licensure or registration in 35 states, across both FFS and MCO models.

Commissioner Discussion

Commissioners raised several questions and clarifications. Multiple commissioners noted inconsistencies in data on spread pricing, particularly differences between survey findings and state legislation, and emphasized the need to better distinguish regulatory actions from statutory provisions. There was also confusion regarding FFS versus MCO models; while spread pricing may be more feasible in MCOs due to negotiated rates, current data does not clearly confirm its prevalence. Additional questions focused on gaps in Medicaid PBM oversight relative to Medicare and commercial markets, as well as the evolving role of generics. Commissioners also underscored the importance of clarifying PBM structures (at-risk vs. administrative). They also suggested further

exploration of the impacts on independent and rural pharmacies, network design, patient cost-sharing, and provider challenges with shifting formularies.

INTRODUCTION TO MEDICAID PROGRAM INTEGRITY

This session discussed Medicaid program integrity (PI) and its impact on fraud, waste, and abuse (FWA).[1] MACPAC staff found that FWA occurs in Medicaid, but accounts for a small portion of program spending, and its true scale is unknown. From 2019-2024, prevented or recovered Medicaid FWA totaled $11,125,000,000 or 0.34 percent of federal Medicaid spending. The federal government, states, and health plans have statutory and regulatory PI responsibilities, yet key issues remain in PI-related federal-state collaboration and PI in managed care.

Federal program integrity (PI) responsibilities are primarily distributed across CMS and the HHS Office of the Inspector General (OIG), which manages most of the workload. CMS provides essential training and technical assistance, conducts investigations and audits via Unified Program Integrity Contractors (UPICs), and conducts oversight of state PI functions and PERM. The HHS OIG conducts oversight and investigations and provides guidance and alerts specific to FWA. The HHS OIG is also tasked with evaluating and managing Medicaid Fraud Control Units (MFCUs) and can exclude providers from federal health care programs. These efforts are bolstered by the Department of Justice, which investigates major fraud cases and coordinates law enforcement efforts alongside HHS.

At the state level, Medicaid agencies handle daily operations, including prevention, detection, preliminary investigations, and recoveries, as well as oversight of managed care plans. This includes state participation in PERM and use of state MFCUs. Health plans also have responsibilities: they must maintain mechanisms to identify and verify that beneficiaries receive services, and report identified overpayments within 30 days.

Several significant challenges exist within federal oversight and managed care program integrity. At the federal level, Unified Program Integrity Contractors (UPICs) engage in limited Medicaid PI activities, but CMS has not communicated about state best practices. Additionally, the Medicaid Integrity Institute (MII) has insufficient resources, and there is limited utilization of findings from state single-audits. Within managed care, state and federal agencies have restricted insight into FWA occurring in provider networks. Managed care plans themselves often report very few cases of fraud and a low number of overpayments, which may be attributed to under-resourced Special Investigation Units (SIUs) or disincentives for plans to pursue FWA.

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[1] See slides 4 and 5 of the presentation for definitions. https://www.macpac.gov/wp-content/uploads/2026/04/08_April-Slides_Medicaid-Program-Integrity.pdf

In previous years, MACPAC has recommended ways to improve PI efficiency and enhance state PI capabilities by reviewing and streamlining effective oversight and tools for detecting FWA. Other previous work targeted improving the effectiveness of state PI activities by examining policy design and implementation of effective state PI programs, establishing pilot programs to test improvements, and utilizing the recovery audit contractor (RAC) to provide state flexibility. MACPAC's current work on PI focuses on identifying how the federal government assists state PI, analyzing barriers that limit the federal government's ability to assist states, and identifying areas where states need additional assistance or where assistance overlaps with state activities.

Commissioner Discussion

Several commissioners expressed the importance of differentiating between unintentional mistakes and fraud. Claiming that administrative errors or poor policy constitute fraud exaggerates perceptions of how often fraud occurs and can harm providers and beneficiaries. Furthermore, commissioners discussed the need for PI practices that focus on FWA prevention. As FWA is difficult to track, expensive to monitor, and lengthy to prosecute, identifying its sources and who is most responsible can help build programs that target the root of the problem before it develops.

Commissioners requested that MACPAC staff, as they conduct interviews with states, ask how states are structuring their PI initiatives. Learning how states interact with Medicaid Fraud Control Units (MFCUs), the Office of Inspector General (OIG), and the Department of Health and Human Services (HHS) will help establish a streamlined series of best practices. Commissioners also requested more information about how FWA will be tackled within the context of managed care. Some stated that PI initiatives tend to be tailored to fee-for-service contexts, without adequate consideration of the growing presence of managed care.

Many commissioners also questioned whether CMS could do more to enable states to protect against FWA, rather than focusing exclusively on monitoring. They highlighted the importance of continuing to collect accurate data on FWA to inform PI as fundamental to building strong future programs. The session concluded with a reiteration of the need for greater clarity in defining FWA and on how PI should uniquely address FWA in managed care and FFS settings.

INTENSIVE COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES: FINDINGS FROM FEDERAL AND STATE REVIEW

This session is a continuation of MACPAC's children and youth behavioral health (BH) work. The session was a continuation of phase 2 of a 3-phase plan, focusing on access to services that prevent out-of-home placement: intensive care coordination or targeted case management, high-fidelity wraparound, mobile crisis response, crisis

stabilization, and respite. MACPAC's June 2021 report to Congress describes how Medicaid-covered youth with significant mental health conditions often experience challenges with accessing BH services and report higher rates of residential treatment than those who are privately insured.

In 2022, about 16 percent of children (age 12-18) received mental health services; the most common mental health diagnoses among them were anxiety disorders, conduct disorders, and depressive disorders. Access challenges for beneficiaries from Medicaid coverage policies, a lack of coordination among multiple agencies, and workforce constraints.

Current federal laws and regulations are meant to ensure access to appropriate BH services in the least restrictive setting for Medicaid children and youth (e.g., Americans with Disabilities Act of 1990, Olmstead v. LC). In 2013, CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) provided joint guidance on key BH-related HCBS that had been shown to improve health outcomes for children and prevent out-of-home placement.

Policy decisions regarding program BH benefits are made by states, within federal requirements, to meet state-specific needs. States may choose to cover intensive community-based BH services through optional benefit categories, including state plan authorities and waivers. Each waiver authority has different geographical requirements, diagnostic eligibility criteria, and enrollment caps. State plan authorities and waivers can be used to deliver the study services within non-restrictive settings. The Early and Periodic Screening, Diagnostic, and Treatment requirement entitles all Medicaid-enrolled children up to the age of 21 to services through the categorically needy pathway, including those without a formal diagnosis of serious emotional disturbance. States also use non-Medicaid authorities and other federal funds (e.g., Title IV-E of the Social Security Act and SAMHSA Mental Health Block Grants) to support access to intensive community-based BH services for Medicaid-enrolled children and youth.

MACPAC staff also shared findings from federal and state policy scans, detailing the state plan and waiver authority states utilize to deliver the five program-defined services. They noted that states have extensive flexibility in covering these services, leading to inconsistent coverage for beneficiaries nationwide.

Commissioner Discussion

Members expressed concern regarding the gap between the availability and actual utilization of the five program-defined services, noting that some services remain inaccessible to Medicaid enrollees. Discussion focused on the difficulty of rate-setting for behavioral health services—specifically targeted case management—while highlighting how carve-outs and the siloed nature of service delivery hinder access.

Members emphasized the need for better coordination across care settings, noting that the burden of managing conditions like depression and anxiety increasingly falls on primary care providers. They also raised questions about clinical and educational integration.

Commissioners also discussed how workforce shortages—which may be partially driven by inadequate payment rates—could be mitigated by ensuring competitive reimbursement and exploring how technologies, such as AI and assistive tools, could supplement the caregiving cohort.

Members expressed interest in research to quantify how geography, race, and ethnicity influence service availability and access to care. The Commission requested data and best practices on reimbursement rates and youth-centered payment models to help states effectively fund high-ROI behavioral health services, such as crisis stabilization.

The Commission emphasized the critical nature of this work, noting that adequate behavioral health services are essential to dismantling the school-to-prison pipeline and preventing the diversion of millions of dollars into high-intensity care that could be avoided with more robust outpatient support. While no formal recommendation was made during this session, MACPAC staff will conduct stakeholder interviews this spring and summer and return in the fall to present their findings.

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