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MACPAC Holds October 2026 Meeting

On October 29 and 30, 2026, the Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission (MACPAC) held a public meeting, which included the following sessions:

- Hospital Cost Drivers: Literature Review Findings,
- Drug Price Negotiation in the Medicaid Program,
- Work Requirements Monitoring: Updates on State Implementation,
- Medicaid Work Requirements: State Panel, and
- Full-Benefit Dually Eligible Individuals Enrolled in Medicare Advantage Special Needs Plans (SNPs)

The full meeting agenda and session presentations are available here.

MACPAC EXAMINES HOSPITAL COST DRIVERS

In this session, MACPAC staff presented findings from an ongoing literature review examining drivers of hospital costs and spending and their implications for Medicaid hospital payment policy. Medicaid programs are required to cover inpatient and outpatient hospital services, including non-practitioner labor, medical supplies, and operating costs, which together account for a significant portion of healthcare spending. Based on their literature review findings, MACPAC staff identified several hospital cost drivers, including labor, administration, utilization, technology, and specialty drugs and therapies. MACPAC staff also outlined plans for stakeholder interviews covering Commissioner-recommended topics, including utilization of high-acuity care, accessibility of outpatient services, and workforce shortages in rural areas.

Commissioner Discussion

Discussion focused on the importance of distinguishing between hospital costs and hospital spending, and identifying how payment rates, utilization, and consolidation contribute to spending trends. Commissioners requested further examination of shifts toward higher-acuity services, access to outpatient care, and facility fees. Commissioners also requested additional analysis of market concentration, private equity hospital acquisitions, and the relationship between ownership and hospital staffing, utilization, and Medicaid services.

Commissioners highlighted the challenges facing rural hospitals, including physician shortages, limited access to primary and preventive care, and financial pressures associated with maintaining access to care. Commissioners expressed interest in comparing hospital costs and spending across rural and urban areas and examining how state policies and staffing requirements may affect hospitals with lower patient volumes. MACPAC staff plan to follow up on a Commissioner's question regarding the consideration of state-directed payments in the final analysis. In January, staff plan to present findings from the policy compendium and ongoing literature review.

MACPAC REVIEWS DRUG PRICE NEGOTIATION IN MEDICAID

In this session, MACPAC staff reviewed the Medicaid Drug Rebate Program (MDRP), the most-favored-nation (MFN) pricing framework, and three Center for Medicare and Medicaid Innovation (CMMI) models: the GENErating cost reductions fOr U.S. Medicaid (GENEROUS) Model, Cell and Gene Therapy (CGT) Access Model, and Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model. MACPAC staff discussed how the models may interact with existing federal and supplemental rebates, their potential effects on Medicaid spending and beneficiary access, and factors influencing voluntary participation by states and manufacturers.

Commissioner Discussion

During the discussion, Commissioners requested greater visibility into which drugs manufacturers offer through GENEROUS and which drugs states select. One Commissioner emphasized that additional discounts could provide meaningful savings for states and requested follow-up on retroactive rebates, CGT safe harbors, and whether multiple rebate requirements could encourage higher launch prices. Another Commissioner asked MACPAC staff to examine rebate collection, reconciliation, and auditing, including whether states receive all amounts and how 340B interacts with supplemental rebates. Other Commissioners requested analysis of CGT performance measures, long-term outcome tracking, managed care implications, pediatric and adolescent access, and generic-drug spending trends.

Commissioners discussed the potential for additional drug savings and requested greater transparency regarding manufacturer and state participation, the drugs covered by the models, and how rebates and negotiated prices would interact. Commissioners also raised questions about administrative requirements and whether the models could provide meaningful savings to states. Commissioners flagged concerns surrounding transparency, administrative complexity, and the difficulty of determining actual drug costs. Several Commissioners supported examining a simpler, more accountable payment structure. MACPAC staff will hold a panel during the December 2026 meeting and a technical expert panel (TEP) of government officials, drug pricing experts, manufacturers, and other stakeholders, followed by a

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presentation of key themes in March 2027. Subsequent work will examine actual savings, coverage and access implications, participation barriers, and opportunities to improve transparency.

MACPAC REVIEWS STATES' IMPLEMENTATION OF MEDICAID COMMUNITY ENGAGEMENT REQUIREMENTS

During this session, MACPAC staff presented findings from its monitoring of states' implementation of Medicaid community engagement (CE) requirements under Centers for Medicare & Medicaid Services' (CMS) interim final rule with comment (IFC). The presentation focused on state readiness, medical frailty determinations, beneficiary outreach, and federal and state reporting. MACPAC staff noted that most states have made progress toward January 1, 2027, implementation, although many anticipate continued information technology (IT) system challenges after implementation, given data availability, staff capacity, and evolving federal guidance. MACPAC staff reviewed implementation approaches such as ex parte validation, self-attestation, medical-frailty assessment frameworks, and good-faith implementation exemptions, as well as ongoing litigation, new federal guidance, and early implementation experiences.

Commissioner Discussion

Commissioners raised concerns about whether beneficiaries will understand the requirements and receive sufficient assistance to demonstrate compliance or qualify for exemptions. Discussion addressed confusing notices, nonresponse to state requests, staffing and training, and the capacity of state systems and call centers to manage increased workloads. Commissioners also expressed interest in understanding how work requirement-related coverage losses differ from ordinary Medicaid renewal outcomes. Commissioners emphasized the need for reliable reporting to distinguish procedural coverage losses from determinations of ineligibility and to assess implementation effects on beneficiaries. MACPAC staff plan to return in December with monitoring updates and to investigate questions raised about hardship processes, payment rates, and implementation experiences.

MACPAC HEARS FROM A PANEL ON STATE IMPLEMENTATION OF MEDICAID COMMUNITY ENGAGEMENT REQUIREMENTS

In this session, MACPAC staff and Commissioners heard from a panel of state and provider representatives on the implementation of Medicaid CE requirements. The panel primarily focused on topics including state implementation efforts, medical frailty determinations, beneficiary communication, and administrative capacity. Panelists discussed challenges, including preparing eligibility systems and staff, as federal guidance and implementation processes continue to evolve. Commissioners raised specific concerns that the medical frailty determination makes it challenging to identify

individuals with disabilities. Commissioners asked panelists about implementation timeliness, documentation requirements, and the potential for federal audits. Panelists described the need for additional time and flexibility to test systems and refine procedures.

Commissioners also raised concerns about beneficiaries who do not respond to state notices and about the risk that eligible individuals may lose coverage due to administrative barriers. Discussion addressed opportunities to improve beneficiary communication, identify medically frail individuals, and support eligibility workers and providers assisting enrollees. Commissioners suggested follow-up work including tracking employment outcomes and medical frailty determinations.

MACPAC DISCUSSES SPECIAL NEEDS PLANS FOR DUALLY ELIGIBLE BENEFICIARIES

In this session, MACPAC staff presented findings from a policy and literature review focused on dually eligible individuals in Medicare Advantage Special Needs Plans (SNPs). MACPAC staff focused on Chronic Condition SNPs (C-SNPs) and Institutional SNPs (I-SNPs), which, unlike Dual Eligible SNPs (D-SNPs), are not required to contract with state Medicaid agencies or coordinate Medicaid benefits. In their review, staff found an increase in C-SNP availability and dually eligible beneficiary enrollment.

Commissioner Discussion

Commissioners expressed concern that rapid growth in C-SNP and I-SNP enrollment among dually eligible individuals could complicate state efforts to integrate Medicare and Medicaid services. In their discussion, Commissioners highlighted families' difficulty and confusion when navigating plan options and recommended eliminating financial incentives for brokers who direct beneficiaries away from integrated plans into unintegrated coverage. Commissioners also urged MACPAC staff to examine corporate ownership patterns, assess plan discharge rates to integrated community settings, and conduct qualitative research directly with beneficiaries to understand their perspective on care integration.

Overall, Commissioners agreed that the lack of state oversight and coordination in C-SNPs and I-SNPs hinders broader state integration strategies and leaves beneficiaries at risk of fragmented care. Commissioners plan to review further baseline data and explore potential policy recommendations in upcoming meetings.

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