



MACPAC Holds September 2026 Meeting

On September 24 and 25, 2026, the Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission (MACPAC) held a public meeting, which included the following sessions:

- Community Engagement Requirements in Medicaid: Interim Final Rule and Monitoring Framework,
- Panel on Community Engagement Requirements: Key Interim Final Rule Provisions,
- State Directed Payment and Provider Tax Proposed Rule, and
- Inpatient Hospital Payment Index: Comparison Across States

The full meeting agenda and session presentations are available [here](#).

MACPAC EXAMINES MEDICAID COMMUNITY ENGAGEMENT REQUIREMENTS: INTERIM FINAL RULE AND MONITORING FRAMEWORK

In this session, MACPAC staff reviewed the Centers for Medicare & Medicaid Services' (CMS's) interim final rule with comment (IFC) implementing Medicaid community engagement (CE) requirements for certain adults in the Medicaid expansion group and applicable Section 1115 demonstrations. Staff summarized key provisions, including individuals subject to the CE requirements, exclusions and exceptions from the CE requirements, state verification requirements, beneficiary outreach requirements, and additional CMS resources. MACPAC staff also reviewed ex parte verification, noncompliance procedures, and current litigation challenging provisions of the IFC.

Staff highlighted two implementation concerns raised in its [comments](#) to CMS: the need for clear state guidance and protection against coverage loss due to avoidable administrative barriers. Staff emphasized that states should first use reliable information to verify exclusions and compliance before requesting additional documentation from beneficiaries. Staff also noted that CMS has issued outreach



materials and medical frailty guidance, with additional guidance expected before implementation.

Staff further outlined MACPAC's Monitoring Framework through which staff will monitor four key areas related to state implementation and ongoing operationalization of CE requirements, including state readiness, medical frailty, beneficiary outreach, and federal and state reporting. The Commission is strongly interested in the CE policy and will return in October with findings from its monitoring work for further discussion.

MACPAC CONSIDERS KEY MEDICAID COMMUNITY ENGAGEMENT REQUIREMENT PROVISIONS

MACPAC Commissioners and other panelists discussed key aspects of the IFC, CMS resources available to states, and areas that need additional clarification and guidance. Panelists described how states are using CMS guidance to develop medical frailty determinations, verification processes, eligibility system changes, and beneficiary outreach. The panelists noted that states expect to rely on self-attestation and manual processes as they refine their systems in 2027.

Commissioners questioned whether states could accurately and fairly implement CE requirements by January 1, 2027, and whether state systems, data, and workforces are adequately prepared for implementation. Commissioners raised concerns about the quality of data used to identify medical frailty, the potential need for workers to interpret clinical information to determine eligibility, and the documentation and administrative burden associated with determining whether individuals meet CE requirements. Commissioners also discussed presumptive eligibility, verification of education and community service, appeals capacity, and the potential for increased procedural denials. Panelists noted that CMS guidance has been helpful thus far, but emphasized that implementation guidance will need to continue to evolve as states refine their processes.

Discussion focused on the risk that eligible individuals could lose coverage due to confusing notices, documentation requirements, or eligibility processing delays. Other concerns included how states are engaging hospitals, federally qualified health centers, managed care organizations, and community groups in outreach and renewal efforts; preparing for increasing appeals and hearing workloads; and ensuring future audits appropriately account for good-faith implementation decisions made before federal guidance is finalized.

Commissioners also discussed how MACPAC could support states. Panelists recommended identifying data sources that could strengthen ex parte verification and

sharing medical frailty approaches that have proven effective and can withstand verification and potential audits.

MACPAC DISCUSSED PROPOSED RULES ON STATE DIRECTED PAYMENTS AND PROVIDER TAXES

In this session, MACPAC staff presented an overview of two proposed CMS rules to implement statutory limits on health care-related taxes (provider taxes) and state directed payments (SDPs) enacted under the 2025 Budget Reconciliation Act. The provider tax rule freezes existing tax arrangements enacted as of July 4, 2025, eliminates the 75/75 test, creates a new permissible class for health insurers, and phases down safe harbor thresholds in expansion states to 3.5% by FY 2032. The proposed SDP rule introduces service and provider level limits tied to Medicare-based rates: 100% of Medicare for expansion states and 110% for non-expansion states while phasing down grandfathered arrangements by 10 percentage points annually starting in 2028. MACPAC staff also reviewed MACPAC's submitted comment letters to CMS.

In its Medicaid Managed Care State Directed Payments proposed rule [comment letter](#), MACPAC expressed concern about proposals limiting state flexibility to use payment as a tool to achieve policy goals and implement innovative payment models, the complexity and burden that administration of Medicare-based payment rate limits at the provider and service level would create, the need for additional guidance on when actuaries can include certain assumptions to meet actuarial soundness requirements without being considered implicit SDPs, and the need for CMS to clarify SDP limitations for providers like children's hospitals with no or minimal Medicare billing.

In its Indirect Hold Harmless Threshold proposed rule [comment letter](#), MACPAC supported ongoing reporting of provider tax information at the provider level such that the financing data could enable analysis of net payments for specific providers to help with understanding how provider tax limits affect payment rates and subsequent outcomes, raised a concern that the elimination of the 75/75 test removes a pathway for states to raise revenues more broadly, and highlighted challenges with respect to requiring application of the safe harbor on a federal fiscal year basis to taxes collected on a state fiscal year basis.

Commissioner Discussion

During this discussion, Commissioners advocated for ongoing monitoring, including gathering additional detail from states about what is happening on the ground and what additional policy levers they are considering. Commissioners noted interest in an examination of impact differences between Medicaid expansion vs. non-expansion states, with a focus on different experiences in changes to access. Commissioners also

highlighted a desire to follow closely as policy evolves and the rules are finalized, raising concerns about the complexity and burden of the proposed rules, the impact on access to care (and need to monitor impact of these rules on access), the fact that the impact score of both rules exceeded statutory scoring of impact, and the need to think about provider engagement differently within the context of other barriers to Medicaid participation (delayed payments, bureaucracy, documentation requirements) to maintain provider participation and access to care.

Regarding the SDP proposed rule, Commissioner discussion highlighted the importance of monitoring the impact on access alongside other Medicaid policies, including work requirements and redeterminations, with a focus on underserved areas, particularly rural and tribal areas. Commissioners also discussed the fragility of healthcare systems, particularly in rural and underserved areas, noting the potentially disruptive impact of the payment limitations in the proposed rule, urging CMS not to wait for hospitals to close or go bankrupt before intervening. Commissioners raised concerns about value-based purchasing and other innovative models' ability to continue within the SDP framework proposed.

Regarding the Hold Harmless proposed rule, Commissioners raised a concern that CMS seeks to limit provider taxes generally, thereby preventing states from shifting taxes elsewhere. Commissioners also expressed interest in learning more about the levers states, particularly expansion states, are considering for the future, given that they will no longer be able to rely as much on provider taxes for the non-federal share.

Commissioners requested that future MACPAC work include direct engagement with state officials and comparative analyses between expansion and non-expansion states to evaluate long-term access trends. Commissioners agreed to continue to monitor implementation challenges, provider participation, and beneficiary access as these proposed rules progress.

MACPAC EXAMINES INPATIENT HOSPITAL PAYMENT INDEX ACROSS STATES

During this session, MACPAC staff reviewed findings from MACPAC's updated inpatient hospital payment index, which compares inpatient hospital payment levels across states and relative to the national average. MACPAC originally developed the index in 2017 to provide a more comparable measure of fee-for-service (FFS) hospital payment across states. The updated analysis, based on calendar year (CY) 2022 data, accounts for managed care spending, current regulations governing average commercial rates through SDPs, and newer data sources that provide information on encounter claims, payment amounts, and supplemental payments. MACPAC staff plan

to present a comparison of Medicaid inpatient hospital payment to Medicare at a subsequent meeting.

Commissioner Discussion

Commissioners largely supported the updated analysis, though raised considerations for future work. Commissioners specifically noted the need to better understand the drivers of variation in hospital payments across states and suggested examining differences by hospital type and geography, including rural vs. urban, frontier, public, teaching, critical access, and children's hospitals. Commissioners also suggested exploring how provider financing affects net payments, whether Medicaid expansion is associated with state variation, and the limitations of using CY 2022 data given more recent policy change. During the discussion, Commissioners expressed interest in comparing Medicaid payments with Medicare rates and examining outpatient hospital payments.

This Applied Policy® Summary was prepared by [Lexi Hartranft](#) with support from the Applied Policy team of health policy experts. If you have any questions or need more information, please contact him at lhhartranft@appliedpolicy.com or at (202) 558-5272.