Budget Justification

Justification of Appropriations Request for the Committee on Appropriations for Fiscal Year 2026

June 2025

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Justification of Appropriations Request Fiscal Year 2026

Table of Contents

Overview

The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services (HHS), and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP).

The U.S. Comptroller General appoints the 17 Commissioners, who come from across the United States and bring expertise and a wide range of perspectives on Medicaid and CHIP. They include providers, health plan executives, parents or caregivers of beneficiaries, former federal and state Medicaid and CHIP officials, actuaries, and other Medicaid and CHIP experts.

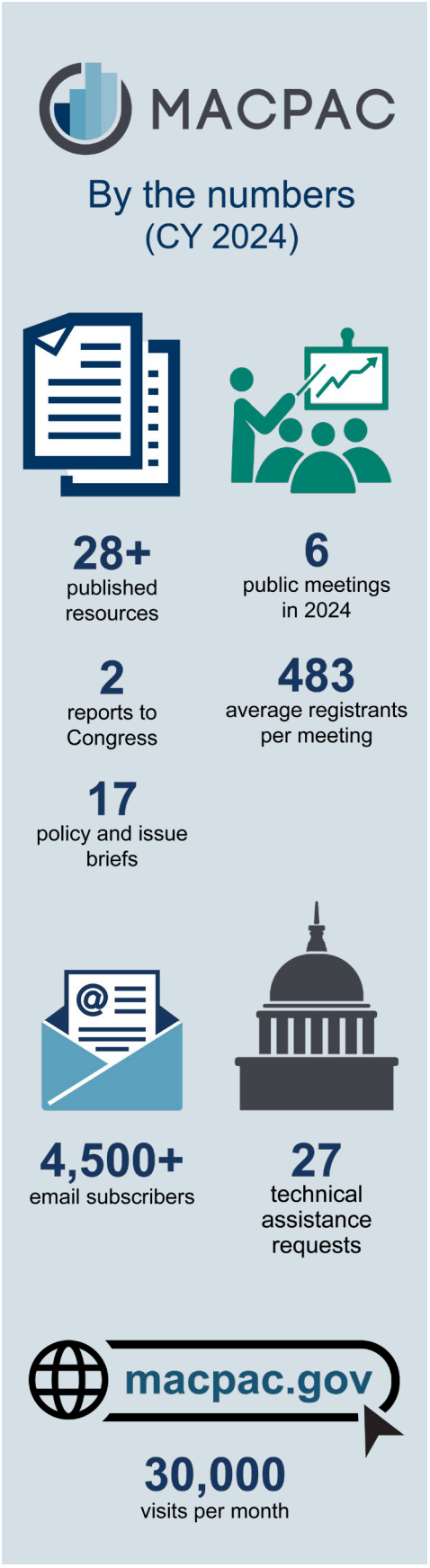
The Commission's authorizing statute, Section 1900 of the Social Security Act, requires that it submit reports to Congress by March 15 and June 15 of each year. The statute also outlines a number of areas for analysis, including:

- payment;
- eligibility;
- enrollment and retention;
- coverage;
- access to care;
- quality of care; and
- the programs' interaction with Medicare and the health care system generally.

The Commission's work is accomplished in multiple ways, including:

- producing key deliverables including reports to Congress, and reviews of reports to Congress and proposed regulations issued by the Secretary of HHS as they relate to Medicaid and CHIP;
- maintaining and building a strong infrastructure for data analysis on Medicaid and CHIP enrollment, utilization, payment, spending, and beneficiary experiences with the programs;
- holding public meetings to hear from outside experts, discuss and deliberate over analyses developed by Commission staff, and vote on recommendations to be included in reports to Congress;
- consulting with the states and other stakeholders;
- coordinating with relevant federal agencies;
- providing prompt, confidential technical assistance to congressional staff; and
- serving as a non-partisan, evidence-based resource on Medicaid and CHIP.

To meet statutory requirements, MACPAC requests $10.698 million for fiscal year (FY) 2026.



Key Research and Activities for Fiscal Year 2026

The Commission's primary responsibility is to provide analysis and advice on Medicaid and CHIP to Congress. In doing so, we prioritize and design our work to be directly relevant to current congressional deliberations on Medicaid and CHIP policy and to anticipate the types of policy and programmatic information that Congress will need in the future. Given that Medicaid and CHIP are partnerships between the federal government and the states, variation in program design, health care markets, and population characteristics across states provide the context for our work in every issue area. State differences in how Medicaid and CHIP are designed and operated create unique challenges to data and policy analysis and the development of federal policy but also provide significant opportunity for learning and program improvement.

Congress has devoted considerable attention to Medicaid and CHIP. To both anticipate and respond to congressional interest, MACPAC has focused analytic work to inform priority topics including access to treatment for mental health conditions and substance use disorders (SUD), spending on prescription drugs, maternal health, integrating care for beneficiaries eligible for both Medicare and Medicaid, financing and payment policies (e.g., provider supplemental payments), and increasing access to home- and community-based services (HCBS).

MACPAC will continue to update descriptive information and key statistics on Medicaid and CHIP, such as information on spending, enrollment, and state policies that congressional staff and others rely on for understanding how these programs function today and how they can be improved.

MACPAC's FY 2026 analytic agenda accounts for federal statutory requirements and issues identified by Congress, HHS, states, and the Commission, and focuses on six policy areas. The Commission identified these areas as priorities during the development of our strategic plan:

- evaluate payment and financing policies for hospitals and prescription drugs;
- assess whether Medicaid payment policies and oversight processes ensure appropriate beneficiary access to medically necessary services in fee-for-service and managed care;
- evaluate access for Medicaid beneficiaries to HCBS and institutional settings, including nursing facilities or intermediate care facilities for individuals with intellectual disabilities;
- identify policy levers to improve care and to create programmatic efficiencies for people who are dually eligible for Medicaid and Medicare across delivery systems;
- assess Medicaid and CHIP policy levers for addressing the behavioral health needs of beneficiaries; and
- examine the effects of federal Medicaid and CHIP policies on enrollment in and renewal of coverage.

Our analytic projects will examine key program issues such as whether policies promote efficiency, access, value, accountability and transparency in program operations and outcomes.

Below we describe the activities MACPAC will undertake in FY 2026 to fulfill its statutory mandate.

Produce analytic reports

Reports to Congress

We will continue to develop MACPAC's required reports to Congress, published annually in March and June. We include issues and analyses in these reports that reflect priority policy areas, oftentimes under active consideration by Congress as well as federal and state Medicaid policymakers. Currently, we expect continued congressional interest in issues such as access to behavioral health services, coverage and access to care for individuals with intellectual disabilities and developmental disabilities, integrating care for dually eligible beneficiaries, HCBS as an alternative to care in nursing facilities, and prescription drug pricing. Commission staff will conduct analyses to support the Commission's deliberations on these issues through individual contributions as well as through competitively bid contracts.

MACPAC reports to Congress are developed over several months and involve the efforts of nearly all of MACPAC's analytic team and communications team. The analytic staff conduct and refine their research, present findings during public meetings for Commissioner deliberation, and identify policy approaches for addressing them. Depending on the scope of our research and the complexity of the policies, staff can engage in project work over a span of 12 months or longer.

MACStats data book

We will continue to produce MACStats, our annual Medicaid and CHIP data book. MACStats is one of the only publicly available data sources that brings together national and state-specific program data in one place, including comprehensive information on eligibility and enrollment for covered populations; Medicaid spending data broken out by population and services such as prescription drugs, supplemental payments to hospitals, long term services and supports (LTSS), and managed care; and program administration. MACStats also provides data on use of services and access to care. MACStats is widely used in the health policy community including by congressional staff, federal agencies, state program officials and policy makers, national and local consumer and beneficiary advocates, industry stakeholders, researchers, and the media.

In addition to the annual print edition, we will update MACStats tables and figures in real-time on the MACPAC website as new data become available. This approach will ensure that congressional staff and others always have access to the most up-to-date Medicaid and CHIP statistics. We will continue our longstanding practice of posting most MACStats exhibits in two formats: as PDF files for ease in reading and printing, and as Excel files, allowing users to download and analyze the data on their own.

To produce MACStats, Commission staff assess the availability and quality of administrative data and national survey data, conduct the data analysis with the assistance of a contractor, develop the tables, and produce the report.

Data book on dually eligible beneficiaries

We will continue our work on a data book on beneficiaries dually eligible for Medicare and Medicaid. The analysis and production of this data book is done in conjunction with the Medicare Payment Advisory Commission (MedPAC). Staff of the commissions review availability and quality of data sources, merge Medicare and Medicaid datasets, analyze spending and utilization among dually eligible beneficiaries. Staff produce exhibits and trend tables depicting spending and utilization across both programs and among different subsets of people including individuals who originally qualified for Medicare because of a disability and people who qualified because they turned age 65. The 2025 publication will include, for the first time, data reflecting Medicaid managed care use among this population. This data book enables the two commissions to speak with one voice on key statistics such as the demographic characteristics, health care use, and program spending of this population.

Comment letters

The Commission stands ready to provide analysis and commentary on administrative actions affecting Medicaid and CHIP, as well as relevant HHS reports to Congress. We always seek to be prepared for these actions (monitoring, for example, the Unified Regulatory Agenda or tracking due dates for statutorily required reports). In some cases, commenting on reports or proposed regulations requires advance analytic work to inform the Commission's response. Comments offered by the Commission draw upon our analytic evidence base.

Other technical resources

MACPAC will continue to update other key Medicaid and CHIP resources that we make publicly available on our website. We publish annotated statutes for Medicaid and CHIP to help users understand provisions of those laws. As changes are made to the laws, we update the notations. To help those in the policy community identify specific provisions in the statutes and the corresponding implementing regulations, the Commission also publishes the Reference Guide to Federal Medicaid Statute and Regulations. This resource serves as informal index to the statutes and regulations to simplify locating provisions. Finally, we maintain a webpage summarizing federal legislative milestones in Medicaid and CHIP dating back to 1965, the year that Congress created Medicaid.

Conduct data analysis and continue building data analytic capabilities

MACPAC has built a sophisticated analytic infrastructure that facilitates independent analysis of large and complex federal and state administrative data sets, federal household sample surveys, as well as private-sector data sources. These sources are described below.

- Transformed Medicaid Statistical Information System (T-MSIS). T-MSIS contains person-level data on Medicaid, eligibility, service utilization, and payments. Although we are now using T-MSIS data in MACStats and other analytic work, we will continue to probe the usability of this data source over the next several years. Having validated top-level data on spending and enrollment for the purposes of MACStats, our work examining more granular codes describing services, diagnoses, and basis of eligibility as well as evaluating the completeness of managed care encounter data continues. As such, we will devote staff resources to understanding the nuances of the data and any quality or validity issues, and documenting these for internal and external use.

  We have continued investments in our analytic capabilities to facilitate deeper analysis of HCBS and behavioral health services. We compared different approaches for identifying HCBS services in T-MSIS data and published an issue brief containing a comparative review of methodological approaches to serve as a resource for the research community. Additionally, we conducted analyses of 2019–2021 T-MSIS data that will result in a series of issue briefs providing HCBS utilization and spending data by LTSS subpopulation and taxonomy that has not previously been available. Similarly, behavioral health services are not easily identifiable in claims data because they may not be specifically identified as behavioral health and can be reported with other services such as a physician or clinic service. Over the next year, we will conduct work to identify individuals with behavioral health conditions, the services they use, and the settings in which those services are provided.

- Other administrative data. Much of our analyses rely on federal administrative data maintained by the Centers for Medicare & Medicaid Services (CMS) such as:
  - Medicaid and CHIP Budget and Expenditure System data, including spending information submitted by states on the Medicaid Quarterly Expense Report (Form CMS-64), Quarterly CHIP Statement of Expenditures (CMS-21), and the Medicaid Program Budget Report (CMS-37);
  - data sources related to the Medicaid prescription drug rebate program, including state drug utilization data, Medicaid drug rebate amounts, National Average Drug Acquisition Cost, and federal upper limit files;
  - the Statistical Enrollment Data System (SEDS) information on the CHIP population;
  - Medicare data sets including the Enrollment Database and Common Medicare Environment files; Medicare Part A, Part B, and Part D claims from the Common Working File; Part D Prescription Drug Event data; and Medicare Part C payment data from Medicare Advantage Prescription Drug files to allow analysis of care provided to 12 million dually eligible beneficiaries; and
  - other CMS data sources including Medicaid and CHIP application, eligibility determinations, and enrollment reports; and National Health Expenditures accounts.

- Survey data. Large federal sample surveys provide important national- and state-level data. Examples of surveys include the American Community Survey, Current Population Survey, Medical Expenditure Panel Survey, Medicare Current Beneficiary Survey, National Ambulatory Care Survey, National Health Interview Survey, National Survey of Children's Health, and the National Survey on Drug Use and Health.

- Proprietary data sets. Such data sets include, for example, the American Hospital Association annual survey. Unlike federal data sets that are made available to MACPAC at no cost, proprietary data sets must be purchased for specific purposes.

In FY 2026, we will once again use multiple data sets to inform the Commission's analysis of key Medicaid and CHIP policy questions and respond to technical assistance requests from Congress. Activities associated with data analysis including managing data use agreements; supervising work of contractors providing computer programming support (one for administrative data and one for federal household surveys); continually assessing data storage, security, and management systems; and documenting the methodologies and definitions used in all our data activities.

Conduct Commission meetings

MACPAC does its most important work in public. Meetings provide the forum for Commissioners to discuss key issues, deliberate policy options, and vote on recommendations that will be included in our reports to Congress.

Public meetings also keep stakeholders – such as organizations representing beneficiaries, providers, plans, and states – apprised of the progress of MACPAC's work. We solicit public comment at multiple points during each Commission meeting as well as through our website. In addition to staff presentations, we regularly bring in outside experts to share insights with the Commission, ensuring that we have the benefit of expertise from states, providers, health plans, consumers, researchers, and others.

We anticipate holding six public meetings in FY 2026. MACPAC meetings use a hybrid format. Commissioners and staff meet in person in Washington, DC.

The meetings are broadcast live so that interested parties can observe the proceedings and provide public comment virtually during the meeting. It has expanded the reach of MACPAC meetings by creating the opportunity for those outside Washington, DC to listen to and provide public comment on the Commission's deliberations with an average registration of nearly 500 participants each meeting.

Importantly, the hybrid format has enabled Medicaid beneficiaries to offer their experience on the program. For example, during recent Commission meetings, panelists included a participant in a self-directed HCBS program in Pennsylvania, a family caregiver, and a person with lived experience in a residential facility. We also hear throughout the analytic cycle from beneficiary advocates regarding access to HCBS and person-centered design for those services.

The hybrid model also supports MACPAC's ability to meet its statutory charge to engage states. State Medicaid officials have joined virtually and weighed in on important and timely issues during public meetings both through public comment and as invited panelists. For example, state agency staff have participated as panelists or provided public comment in virtually every meeting in FY 2024 to date, with representation from multiple Medicaid directors and other staff. This investment in the hybrid meeting format has made them more accessible to Commissioners, stakeholders, and beneficiaries. While MACPAC meetings are in person for Commissioners, the hybrid format allows Commissioners who are unable to travel to Washington, DC to participate virtually.

We will also continue our practice of publishing the meeting transcript and presentation materials on the MACPAC website to both document the Commission's deliberations and extend our reach.

Consult with states

MACPAC is statutorily required to consult regularly with the states and we do so routinely both to gather specific information about state policies and to ensure that state views and concerns are represented as the Commission analyzes different aspects of Medicaid and CHIP. These activities are critical to the Commission's understanding of how Medicaid and CHIP work in different states and how federal policy changes would play out on the ground.

In FY 2026, we plan to consult with states by continuing to:

- conduct listening sessions with state officials (e.g., aging and disability directors, CHIP directors, Medicaid directors, Medicaid medical directors, mental health program directors, developmental disabilities services directors, program integrity leaders);
- invite state officials to participate in panels at public meetings;
- conduct interviews, roundtables, and site visits related to specific policy issues; and
- invite Medicaid and CHIP directors to provide a technical review of all draft report chapters and relevant contractor reports prior to publication.

Coordinate work with key agencies

In FY 2026, MACPAC will maintain its relationships with federal agencies working on issues related to Medicaid and CHIP. MACPAC staff are in frequent contact with leadership and staff at CMS to ensure the accuracy of our work and to stay abreast of agency actions. We also meet regularly with staff of MedPAC and the CMS Medicare-Medicaid Coordination Office on issues related to persons who are dually eligible for Medicare and Medicaid.

We maintain lines of communication and information sharing with other offices within CMS and other HHS agencies and offices, including the Office of the Assistant Secretary of Planning and Evaluation (ASPE), the Administration for Community Living (ACL), the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Administration for Children and Families (ACF) and the Office of the Inspector General (OIG). In addition, we regularly consult with the U.S. Government Accountability Office (GAO) to avoid duplication of effort on work of interest to Congress and with the Congressional Budget Office (CBO) on the budgetary effects of potential recommendations.

Provide expert technical assistance

MACPAC will continue its practice of responding promptly to technical assistance requests from Congress, including staff of committees of jurisdiction, as well as staff from other committees and member offices. Such assistance includes technical review of draft legislation, special data runs, explanations of provisions of Medicaid and CHIP statute and regulations, and information on state policies and practices. These activities are confidential, provided only to the requestor. The confidential nature of these requests also means that they are not shared with Commissioners.

MACPAC also conducts briefings for congressional staff. These are tailored to the specific needs identified by the requestors. Some briefings are geared to new or more junior staff, focusing on program basics, while others, for more experienced staff, dive deeper into more complex issues.

On occasion, MACPAC has testified at state legislative hearings to provide evidence-based research and expert statements for educational purposes.

Although MACPAC staff have full analytic portfolios to support the Commission's deliberations, we have never failed to respond to the technical assistance requests made by congressional staff. We will continue responding to all requests whether they originate with a committee of jurisdiction or another member office to the extent our resources permit. However, should formal demands for MACPAC work increase, there may be pressure on our ability to respond to all requests and we may have to consider prioritizing requests.

Serve as an evidence-based non-partisan resource on Medicaid and CHIP

In the year ahead, MACPAC will continue to serve as an important source of evidence-based non-partisan information on Medicaid and CHIP. The Commission is regularly sought out by the media as a source of unbiased information on Medicaid and CHIP, including both national outlets such as the *Associated Press*, *Axios*, *Bloomberg*, *Congressional Quarterly*, *The Hill*, *Inside Health Policy*, *Kaiser Health News*, *Modern Healthcare*, *NBC News*, *Forbes, the Wall Street Journal*, and *Washington Post*, as well as many local and state media.

MACPAC's work is also frequently cited in highly regarded peer-reviewed journals such as *Health Affairs*, *The American Journal of Managed Care*, the *Journal of the American Medical Association* and the *New England Journal of Medicine*. Policy organizations, including the Bipartisan Policy Center, KFF, Pew Charitable Trusts, and Urban Institute, often cite MACPAC's work. In addition, federal agencies (e.g., CMS, CBO, Congressional Research Service (CRS), GAO) and states continue to cite our products.

In addition to our statutorily required deliverables, MACPAC plans to continue producing other products on a wide range of topics. In FY 2026, we plan to keep building and updating such information by publishing new and updating previously published issue briefs, fact sheets, and policy compendia on a wide range of Medicaid and CHIP topics. We also plan to explore new methods to package and deliver content to state audiences.

Maintain a strong operational infrastructure

MACPAC adopts a practice of continuous improvement to assess our operational needs and systems required to support our core mission to identify opportunities to increase efficiency and to improve outcomes. We plan to continue ongoing strengthening of our agency information technology architecture to improve office IT infrastructure, enhance cybersecurity, implement new workflow management tools, and operate our website. In FY 2026, we will also continue routine updates of end-user and network hardware.

During FY 2026, we will continue our increased focus on professional development of MACPAC staff. To date, we have sought and implemented training sessions and programs to improve specific skills (e.g., data analytics, project management, legislative process) and as a strategy for employee growth and retention. We will continue to ensure that staff receive appropriate training in key functional areas of contract administration; procurement; IT security; financial management; and records retention. In addition, we anticipate contracting for outside technical expertise (e.g., risk management) when needed.

With respect to other operations, we will continue to seek best value for the government in contracts with shared services providers. For example, MACPAC contracts with the General Services Administration, Pegasys Financial Services External Services Branch for accounting, financial management services, and reporting. Payroll services are included in a separate service-level agreement with the General Services Administration, Payroll Services Branch. Like other federal agencies housed in leased space, we are required to pay the U.S. Department of Homeland Security for certain security services.

Justification of Budget Request and Summary

MACPAC is requesting $10,698,000 (Exhibit 1), which represents a $1,293,000 increase over its FY 2024 appropriation. This is the same amount as requested for FY 2025.

This request reflects several factors. The first is the consistently high demand on MACPAC from Congress to analyze and make recommendations on important Medicaid and CHIP policy issues. As the Commission's body of work has grown over the years, there are still new issues of interest to Congress and demand for us to go deeper in areas of policy interest.

Second, costs for all aspects of MACPAC operations are growing due to inflation that is affecting many sectors of the U.S. economy. In particular, retaining and attracting a knowledgeable and highly productive team requires that we keep salaries competitive with those being offered by other employers (both federal and private sector) in the Washington area. Moreover, while we always negotiate with vendors when possible, it is reasonable to expect that costs for such items such as information technology, security services, and meeting facilities will increase.

Until FY 2024, MACPAC was in the unique situation of having available no year funds, which Congress provided in our first appropriation. However, all of MACPAC's no year funds have been expended. In FY 2025, the agency is operating within its annual appropriation alone. We seek an annual appropriation adequate to fund MACPAC's statutory charge given no year funds are no longer available (Exhibit 1).

MACPAC is committed to making prudent decisions with its available resources. Our FY 2026 request reflects our practice of being responsive to external requests, carefully weighing competing priorities, and continually striving to identify ways to both maximize our value as an analytic resource and improve efficiency and organizational effectiveness.

EXHIBIT 1. Appropriations History, Fiscal Years 2010–2026

Fiscal year	Appropriation requested	Funds appropriated	No year funds available[1]	Total available funding[2]
2016	8,700,000	7,765,000	2,300,000	10,065,000
2017	8,700,000	7,765,000	1,327,000	9,092,000
2018[3]	8,700,000	8,480,000	1,515,000	9,995,000
2019	8,700,000	8,480,000	1,288,000	9,768,000
2020	9,000,000	8,780,000	1,134,000	9,914,000
2021	9,265,000	8,780,000	781,811	9,561,811
2022	9,350,000	9,043,000	505,354	9,548,354
2023[4]	9,727,000	9,405,000	573,354	9,978,354
2024[5]	10,053,000	9,405,000	565,354	9,970,354
2025[6]	10,698,000	9,405,000	–	9,405,000
2026	10,698,000	–	–	–

Notes:

– Dash indicates not yet available.

[1] The Patient Protection and Affordable Care Act (P.L. 111-148, as amended) appropriated $9.0 million and transferred $2.0 million in no-year funds from the 2010 CHIP allotment (section 2104(a)(13) of the Social Security Act).

[2]Total available funding reflects the total of remaining funds in MACPAC's no-year fund and annual appropriations.

[3]The unobligated balance brought forward in the no-year fund on October 1, 2018 included an increase of $188,000 due to prior year recoveries processed in FY 2017.

[4] The unobligated balance brought forward in the no-year fund on October 1, 2023 included an increase of $68,000 due to prior year recoveries processed in FY 2022.

[5]The no year fund was exhausted in the first quarter of FY 2024.

[6]MACPAC received funding under the full-year continuing resolution through September 30, 2025 (P.L. 119-4).

Below we outline the resources necessary to carry out our mission of providing expert, non-partisan information and analyses on Medicaid and CHIP in FY 2026. To successfully manage these activities to support Congress, the Commission will allocate funds from the requested budget to the broad areas described below (Exhibits 2 and 3).

EXHIBIT 2. Budget Summary, Fiscal Years 2024–2026 (thousands of dollars)

Category	FY 2024 actual	FY 2025 request	FY 2026 request	Percent change in request from FY 2025 to FY 2026
Salaries and benefits	$5,429	$6,591	$6,607	0.2%
Non-personnel costs	4,529	4,107	4,091	(0.4)
Total	$9,958[1]	$10,698	$10,698	0%

Notes: FY is fiscal year.

[1] MACPAC received $9,405,000 in FY 2024 (Further Consolidated Appropriations Act, 2024 (P.L. 118-47); we used the remaining funds from the no-year account to reach this amount.

Because MACPAC conducts most of its work internally, much of MACPAC's resources will be devoted to staff salaries and benefits (Exhibit 2). Our team of policy analysts produces the work that forms the evidence base for the Commission's recommendations and its reports to Congress and other publications. The team also analyzes administrative and survey data; provides technical assistance to Congress; manages contractors working on research and analytic projects; conducts outreach to state, federal agency officials, and stakeholders; and shares

technical expertise with external audiences by serving on advisory panels and speaking at major conferences. Resident expertise in public policy analysis, health services, research, and data analysis, along with backgrounds working in state and federal governments, health plans, research and policy firms, Congress, and academia allow staff to draw on deep reserves of knowledge and get up-to-speed quickly on new issues of concern to Congress.

Like other employers, MACPAC considers its staff its chief resource and invests accordingly. Prospective and current employees expect or seek salaries competitive with those being offered by other organizations focused on Medicaid policy research and analysis. The agency also must adapt to often unpredictable market increases to employer-paid benefits (for example, health insurance benefits).

EXHIBIT 3. Summary of Requirements by Object Class by Fiscal Year (thousands of dollars)

Object class		FY 2024 actual	FY 2025 request	FY 2026 request	Change from FY 2025 to FY 2026
11.1	Permanent staff	$3,755	$4,523	$4,523	-
11.3	Other than permanent: Commissioners and internships	255	297	293	(4) [1]
12	Personnel benefits	1,419	1,771	1,791	20 [2]
Subtotal, personnel		**5,429**	**6,591**	**6,607**	**16**
21	Travel	143	148	157	9 [3]
23	Rent, utilities, and communications	604	638	579	(59) [4]
24	Printing and reproduction	8	12	10	(2) [5]
25	Research contracts and data analysis services	2,833	2,400	2,468	68 [6]
25	Other contractual services	743	727	697	(30) [7]
26	Supplies and materials	91	94	97	3 [8]
31	Equipment purchases	107	88	83	(5) [9]
Subtotal, non-personnel		**4,529**	**4,107**	**4,091**	**(16)**
TOTAL		**$9,958**	**$10,698**	**$10,698**	**$0**

Notes: FY is fiscal year.

[1] The $4,000 decrease in this budget line is attributed to the elimination of a part-time position offset by increases in Commissioner stipends, which per MACPAC's authorizing statute are tied to the Executive Schedule.

[2] The $20,000 increase in personnel benefits includes increases in benefits for staff and Commissioner payroll taxes in FY 2026.

[3] The $9,000 increase in this budget line is related to increases in Commissioner travel-related expenses offset by reduced costs for in-person guest speakers invited to speak with the Commission.

[4] The $59,000 decrease in this budget line is mostly attributed to reduced costs for office rent and cost savings recognized after migrating to a new telecommunications service provider in FY 2024.

[5] The $2,000 decrease is due to reductions in printing costs associated with MACPAC publications.

[6] The $68,000 increase in this budget line is attributed to increased costs associated with MACPAC's planned analytic agenda.

[7] The $30,000 decrease in other contractual services is mostly attributed to decreases in IT advisory services, mission support services, interagency agreements, and training.

[8] The $3,000 increase in supplies and materials is due to increased costs for technical publications.

[9] The $5,000 decrease in equipment purchases is due to a reduction in computer related equipment purchases anticipated in FY 2026.

MACPAC has made significant investments in its in-house ability to analyze Medicaid program data and other relevant data sources, including federal health surveys and Medicare claims for individuals also covered by Medicaid. At the same time, our vendor contract costs are increasing, as our vendors' fee schedules change year over year and typically reflect their own experience of inflation-driven increased costs. This trend is reflected in

both our research and core operations contracts. Operations staff bring strong backgrounds in accounting, financial management, procurement and contract management, and information technology to ensure that the organization uses resources both prudently and in compliance with all applicable statutes.

MACPAC is also required to compensate its 17 Commissioners at the per diem rate equivalent to Level IV of the Executive Schedule while working on Commission business, including a physician allowance for our Commissioners who are licensed physicians.

Our request for FY 2026 reflects historical patterns of spending on travel as we have resumed holding in-person meetings. The travel line item primarily reflects spending on travel for Commissioners and invited panelists to our public meetings and a modest amount of staff travel to professional meetings and site visits. The equipment purchases line item reflects ongoing and routine replacement of staff computers and peripherals; a comprehensive and multi-year refresh of staff computers we anticipate completing in FY 2025 reduces our projected expenditures in FY 2026. Equipment updates are necessary to ensure that staff have the reliable technology needed to conduct their job responsibilities, and are consistent with industry practice for technology refreshes. We anticipate reduced spending for postage and other costs as well as printing, as MACPAC is printing fewer hard copies of reports and expanding our audience for the electronic versions. We also expect reduced spending for copy editing, which we are now doing in house, and non-recurring training expenses.

In FY 2026, MACPAC budgets staffing at 34 full-time equivalents to support our considerable analytic agenda (Exhibit 5). We anticipate that regular staff turnover may require us to recruit new employees to replace outgoing team members. To recruit and retain specialized staff with the needed expertise, MACPAC must offer salaries competitive with the executive branch and other private, non-profit research organizations in Washington, DC.

EXHIBIT 4. Budgeted Staffing Level by Fiscal Year, Fiscal Years 2022–2026

Fiscal year	Budgeted full-time equivalents
2022	30
2023	33
2024	33
2025	34
2026	34

Legislative Language Request

EXHIBIT 5. FY 2026 Appropriations Language

For expenses necessary to carry out section 1900 of the Social Security Act, $10,698,000. *In fiscal year 2026 and thereafter, for all contracts for goods and services to which the Medicaid and CHIP Payment and Access Commission is a party, the following Federal Acquisition Regulation (FAR) clauses will apply: FAR 52.232–39 and FAR 52.233–4.*

Exhibit 5 represents MACPAC's appropriations language that reflects our FY 2026 requested amount. MACPAC requests additional language in its annual appropriation. In October 2024, the Medicare Payment Advisory Commission (MedPAC) and MACPAC jointly requested two legislative changes to our contracting authority that would allow both agencies to operate more efficiently and grant the same flexibilities afforded to other legislative branch agencies, including GAO, the Library of Congress, CBO, and others. These proposed changes include authority to execute contracts that span multiple fiscal years and certain liability protections afforded by the FAR.

Currently, our agencies must structure the terms of our contracts to align with the federal fiscal year on a 12-month period, and thus must renegotiate or renew all of our contracts at the same time each year, an inefficient and administratively burdensome process. Multi-year contracting authority would allow our Commissions to obtain

more competitive pricing for services we currently purchase on a fiscal year basis by securing best value to the government for longer periods of time.

The text included in Exhibit 5 applies liability protections enacted through the FAR to our agencies, which are otherwise not subject to the FAR. In addition to that text, MACPAC respectfully asks for the below two paragraphs to be added to 41 USC 3904, which would grant the Commissions contracting authority consistent with other legislative branch agencies as described.[1]

> (i) The Medicare Payment Advisory Commission. –
> The Medicare Payment Advisory Commission may use available funds to enter into contracts for the procurement of severable services for a period that begins in one fiscal year and ends in the next fiscal year and may enter into multiyear contracts for the acquisition of property and services to the same extent as executive agencies under the authority of sections 3902 and 3903 of this title.
>
> (j) The Medicaid and CHIP Payment and Access Commission. –
> The Medicaid and CHIP Payment and Access Commission may use available funds to enter into contracts for the procurement of severable services for a period that begins in one fiscal year and ends in the next fiscal year and may enter into multiyear contracts for the acquisition of property and services to the same extent as executive agencies under the authority of sections 3902 and 3903 of this title.

Activities and Outcomes in Fiscal Years 2024-2025

The Commission's analytic work focuses on six core policy priority areas. The Commission identified the priority areas based on MACPAC's statutory charge and areas of congressional interest. While these priorities guide our analytic activities, MACPAC will remain nimble in its ability to redirect analytic resources as the policy environment changes.

Adoption of MACPAC recommendations

The Commission votes on recommendations addressed to Congress, the HHS Secretary, and the states. In 2024, CMS implemented aspects of several MACPAC recommendations related to enrollment, beneficiary engagement, and payment transparency:

State directed payments. MACPAC recommended that the Secretary of HHS make state directed payment approval information publicly available in its June 2022 Report to Congress, which CMS partially implemented in May 2024 through its May 2024 managed care rule. The rule includes provisions requiring states to report all directed payment amounts in T-MSIS. Additionally, CMS is making approved directed payment preprints available on its website. MACPAC also recommended that the Secretary make provider-level data on directed payment amounts publicly available in a standard format that enables analysis. The 2024 rule also required states to publish their evaluation reports, and further noted CMS's intent to make state evaluation results available on Medicaid.gov.

Enrollment for dually eligible individuals. To facilitate Medicaid enrollment among individuals who are dually eligible for Medicaid and Medicare, the Commission recommended that CMS issue guidance to create an exception to the special enrollment period to allow dually eligible beneficiaries eligible for Medicare-Medicaid Plans (MMPs) to enroll on a continuous (monthly) basis (June 2020 Report to Congress). In April 2024, CMS published a final rule that creates a new special enrollment period for dually eligible individuals to select an integrated and aligned dual eligible special needs plan (D-SNP). As CMS is ending the Medicare-Medicaid Plans under the Financial Alignment Initiative, states are transitioning those enrollees to integrated D-SNPs.

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[1] These provisions were included in the Further Continuing Appropriations and Disaster Relief Supplemental Appropriations Act, 2025 H.R. 10445, 118th Congress (2024). https://docs.house.gov/billsthisweek/20241216/CR.pdf

Beneficiary experience. MACPAC recommended that CMS field an annual Medicaid beneficiary survey to collect information on beneficiary perceptions and experience of care (June 2022 Report to Congress). In May 2024, CMS issued a final rule addressing access to care, which required states to develop and conduct an annual enrollee experience survey for each managed care plan (42 CFR 438.66(b)(4) and 42 CFR 438.66(c)(5)).

Medical Care Advisory Committees (MCACs). MACPAC recommended that CMS issue guidance and provide technical assistance to address states' concerns related to challenges in recruiting beneficiaries to participate in medical care advisory committees (MCACs), strategies to facilitate meaningful beneficiary engagement in MCACs, and approaches for providing financial arrangements to support beneficiary participation (March 2024 Report to Congress). CMS addressed this recommendation in May 2024 final rules that clarified how states can provide financial arrangements to beneficiaries without affecting their Medicaid eligibility and planned to release a toolkit with best practices for engaging beneficiaries.

CHIP waiting periods. MACPAC issued recommendations to eliminate waiting periods for CHIP to reduce administrative complexity and promote continuity of coverage for children in 2014 and 2017. CMS eliminated waiting periods in CHIP in 2024.

Key MACPAC accomplishments and activities since the submission of our last budget request (FY 2024 and to date in FY 2025) are described in greater detail below.

Analysis and research

MACPAC's research and analysis includes work conducted by both staff and contractors. This work provides the evidence base for recommendations and other analyses published in our March and June reports to Congress as well as other publications. In brief, activities in FY 2024 and 2025 include:

- examining the relationship between physician payment and access to care beginning with an expert roundtable discussion on financial and non-financial factors affecting physician participation in Medicaid, and challenges and opportunities to evaluate how payment relates to access to care;
- assessing the number and associated spending with state directed payment arrangements used in Medicaid managed care and updating our issue brief on SDPs and supplemental payments, released October 2024;
- examined key issues in oversight of Medicaid managed care programs, including deeper analysis of the external quality review (EQR) process and the tools at states' disposal to ensure accountability and oversight of the health plans operating within their programs;
- building on our previous prior authorization work by examining the current literature and policy context for oversight of artificial intelligence and other forms of automation in prior authorization processes;
- conducting analyses that will update our prior work comparing Medicaid hospital payment across states and to external benchmarks like Medicare;
- assessing federal requirements and state approaches for transitioning older youth to adult coverage and care to ensure continuity of coverage and care as they move from pediatric to adult care environments;
- examining how federal Medicaid policy ensures that children and youth in the child welfare system have access to the care needed to treat their unique needs, the role of state Medicaid agencies and child welfare agencies in the provision of such care, and how the agencies work together;
- examining the unique needs of youth involved in the juvenile justice system and their access to care, and the ways that state Medicaid programs approach transitions in care for children leaving the justice system;
- analyzing the extent to which beneficiaries lose Medicaid eligibility, transition to other sources of coverage (e.g., exchanges), and the barriers to those transitions;
- conducting an analysis of access to covered oral health services for adult Medicaid beneficiaries with intellectual and developmental disabilities;
- beginning an examination of appropriate access to residential treatment for behavioral health for individuals with complex care needs and who need that level of care;

- understanding the Program of All-Inclusive Care for the Elderly (PACE) and how it primarily serves dually eligible beneficiaries who need a nursing facility level of care but can live safely in the community, providing integrated care in 33 states and the District of Columbia;
- continuing our analysis of the ways in which provider payments in HCBS programs can be used as a tool to ensure an adequate HCBS workforce;
- examining state use of flexibilities to implement policies and processes to streamline Medicaid enrollment for individuals who need HCBS; and
- updating our Access in Brief series that compares key measures of access for Medicaid beneficiaries with those covered by private insurance or who are uninsured (e.g., access by race and ethnicity and access for children and individuals with disabilities).

More detailed background on these and other projects follows here, grouped by the Commission's six strategic priorities for its research agenda.

Evaluate payment and financing policies for hospitals and prescription drugs

Financing transparency. In FY 2024, we conducted work to understand barriers to improving the transparency of Medicaid and CHIP financing and made two recommendations to require states to collect and publicly report information on the sources of non-federal share of Medicaid and CHIP spending, including financing methods, state-level financing amounts, and provider-level financing amounts in our June 2024 report to Congress. The Commission has long held that analyses of Medicaid payment policy require complete data on all Medicaid payments that providers receive as well as data on the costs of financing the non-federal share through health-care related taxes, intergovernmental transfers, and certified public expenditures. This work built on our recommendations for CMS to collect data on provider contributions to the non-federal share to provide greater transparency of net payments to hospitals and nursing facilities that we made in the March 2016 and March 2023 reports to Congress. As part of this work, we provided illustrative examples of how provider-level financing data could be used to enhance our understanding of Medicaid gross and net provider payments by using Medicaid financing data made publicly available in Texas. Stakeholders from our interviews stressed the importance of analyzing both gross and net payment amounts when developing payment policy and assessing how these payments are linked to goals of access and quality.

Provider payment. MACPAC has a longstanding portfolio of work to evaluate provider payment policies. We updated prior work documenting base and supplemental payments to hospitals and use of managed care directed payments.

In FY 2024, MACPAC began a comprehensive, multi-year review of hospital payment policies and amounts, including all payments such as base, disproportionate share hospital (DSH), non-DSH supplemental, and directed payments. Using newly available supplemental payment data, we presented information on how supplemental payments were distributed across different types and classes of providers, such as supporting providers that serve a high share of Medicaid and uninsured patients or supporting specific hospital types (e.g., children's hospitals, rural or critical access hospitals).

Finally, we began work to refine and update the fee for service (FFS) inpatient hospital payment index work that we published in 2017. We held a technical expert panel (TEP) including states, federal officials, payment experts, and researchers to assess the availability of data on hospital payment across multiple data sources (e.g., T-MSIS, CMS-64 financial management reports, state directed payment preprints) and to discuss ways to refine any adjustments needed to control for variations in case mix and wage costs across states. Building on the findings from the TEP, we have started work to update the hospital payment index. The new index will seek to expand on the prior work to include both inpatient and outpatient hospital services as well as include both FFS and managed care payments. Similar to the prior index, the updated work will compare hospital payment both across states as well as to external benchmarks such as Medicare or provider costs. We anticipate this work will take some time to complete due to the complexity of the analysis.

Prescription drug pricing and spending. While prescription drug spending accounts for a relatively modest share of Medicaid expenditures, these costs are expected to rise sharply over the next several years. Our prior work looked at the impact of development of new high-cost, specialty drugs on program spending, tools to manage drug spending, and Medicaid policy barriers that may impede management of drug spending.

In FY 2024, MACPAC convened a roundtable of experts to discuss the unique coverage and payment challenges physician-administered drugs may present and what additional tools may be needed to address these challenges, an area where little research has been conducted. Many high-cost specialty drugs are physician-administered (e.g., oncology). Furthermore, many of the high-cost specialty drugs in the pipeline (e.g., cell and gene therapies) will likely require physician administration. As such, physician-administered drugs are expected to be a key driver of Medicaid drug spending in the future. Because physician-administered drugs are frequently covered under the medical benefit instead of the pharmacy benefit, states often have different payment and coverage policies for physician-administered drugs than they use for other outpatient drugs obtained from a pharmacy. The roundtable highlighted the tension payers face in paying a mark-up on the drug cost versus overall payment adequacy. Participants also discussed potential strategies for payment to reflect the upfront risk posed by purchasing drugs while avoiding an excessive mark-up for very high-cost drugs. Similarly, the roundtable discussed the greater challenges of managing drug spending and utilization under the medical benefit and potential benefits of integrating the clinical teams under the medical and pharmacy benefits. Although MACPAC does not have specific project work on cell and gene therapies for this work cycle, we are monitoring developments in this space.

Mandated DSH study. Starting in 2016 and ending in 2024, the Commission analyzed the relationship of state DSH allotments to (1) changes in the number of uninsured individuals, (2) amounts and sources of hospitals' uncompensated care costs, and (3) the number of hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations. We consistently found that there is no meaningful relationship between state DSH allotments and the three factors we had been charged with studying. In addition, we provided updates on the uninsured rate during the COVID-19 pandemic and changes to DSH allotments, hospital uncompensated care, and hospital margins during the public health emergency (PHE). The Commission reiterated its recommendations included in the February 2016, March 2019, June 2019, and June 2023 reports to Congress on DSH policy.

In future years, we will continue to assess DSH in the context of other Medicaid payments, including non-DSH supplemental payments and managed care directed payments to hospitals. Increases in non-DSH supplemental payments and directed payments reduce a hospital's uncompensated care costs and thus reduce the amount of DSH payments that a hospital can receive, leading some states to use directed payments instead of DSH to support safety-net hospitals. As such, MACPAC will include DSH as a part of a broader assessment of total hospital payments such as the work we have started to update the hospital payment index.

Assess whether Medicaid payment policies and oversight processes ensure appropriate beneficiary access to medically necessary services in FFS and managed care

Managed care. Managed care is the dominant delivery system in Medicaid, accounting for over half of all benefit spending, including substantial enrollment across all major eligibility groups. In FY 2024, we initiated a new body of work to take a deeper look at Medicaid managed care policies to consider whether statute and regulation are structured to produce access, value, and efficiency. We have looked at multiple aspects of managed care policy as described below.

- **Denials and appeals.** In FY 2024, the Commission assessed how states and CMS monitor denials of services to mitigate inappropriate denials and how the appeals process works to ensure that beneficiaries inappropriately denied services can obtain medically necessary care. In the March 2024 report to Congress, the Commission made seven recommendations to strengthen denial and appeals monitoring and oversight and to improve the process for beneficiaries.
- **Transparency of directed payments.** Managed care directed payments are a large and growing share of Medicaid spending. However, little information is reported publicly about these payments and it is unclear what effect they have on quality and access to care for Medicaid beneficiaries. We updated our issue brief examining the use of directed payments with a review of directed payments approved by CMS between February 2023 to August 2024. Our analysis found that the number of directed payment arrangements and

associated spending has increased substantially since our review of directed payment arrangements approved between July 2021 to February 2023. The issue brief also highlighted the changes to directed payment policy included in CMS's 2024 final managed care rule. We highlighted the fact that about three-quarters of directed payment spending would be made through uniform rate increases, of which the vast majority would be made through separate payment terms. The 2024 final managed care rule phases out the use of separate payment terms by 2027.

- **External quality review.** MACPAC started work in the 2022-2023 cycle examining how the mandatory external quality review (EQR) process supports states' ability to conduct oversight of and hold managed care accountable to federal and state requirements. Findings from this work suggested that while states and other stakeholders find EQR useful, there may be opportunities to consider a greater focus on outcomes over process information, greater transparency in reporting of findings, and a clearer and more robust role for CMS in oversight of the process. We paused this work to see what EQR provisions would be finalized in the 2024 managed care rule. While the 2024 managed care rule addressed some of the findings of our research by including outcomes data for three of the four mandatory EQR activities, there are still opportunities for additional improvements to the EQR process. The March 2025 report to Congress included recommendations to require outcomes data for the compliance review activity not included in the changes made in the 2024 managed care rule, to increase standardization of the EQR annual technical report to help stakeholders find, interpret, and align EQR findings, and to make the reports more accessible and transparent by requiring CMS to post state EQR reports in a central location.
- **Accountability.** In recent years, the effective oversight of Medicaid managed care programs to ensure beneficiaries have appropriate access to needed services has increasingly become a priority for stakeholders. We kicked off a project to better understand the tools available to federal and state regulators to oversee states' managed care programs. Specifically, this work examines how CMS regulates state Medicaid agencies and ensures compliance with federal regulations, and how state Medicaid agencies oversee their contracted MCOs' performance and hold plans accountable to contractual obligations or performance expectations. The project also will explore whether there is any evidence that certain tools improve plan performance over time. As part of this work, we will conduct a federal policy review, a scan of state managed care contracts and request for proposals, and stakeholder interviews with state Medicaid officials, federal officials, managed care plans, policy experts, and beneficiary representatives.

Prior authorization and automation. In 2024, MACPAC published an issue brief that provides background on the prior authorization process and its role in Medicaid. Through this work, we learned that payers have begun to incorporate technology, including artificial intelligence (AI), to automate parts of the prior authorization process. We are using the term automation specifically to refer to technological tools such as algorithms and AI that supplement or replace human action or decision making. Automation may be used for myriad purposes in the prior authorization process, including to help keep clinical guidelines up to date, determine whether a prior authorization is required, or generate a prior authorization recommendation. Automation in the prior authorization process may lead to efficiency, cost reduction, and standardization, which may in turn lead to improved experiences for patients and reduced burden on providers. However, automation may also lead to reduced oversight over prior authorization decisions and increased opportunity for biased or incorrect denials. These tradeoffs are further complicated by a general lack of clarity and transparency around the role of automation in the Medicaid prior authorization process today. We have started work to investigate the role of automation in the Medicaid prior authorization process and explore how managed care plans, states, and the federal government oversee its use.

Evaluate access for Medicaid beneficiaries to HCBS and institutional settings, including nursing facilities or intermediate care facilities for individuals with intellectual disabilities

HCBS. MACPAC assessed opportunities to address access barriers and reduce complexity in administering HCBS programs. In FY 2024, MACPAC engaged in a foundational analysis of Medicaid claims data using T-MSIS. This effort was designed to establish a baseline of Medicaid data from which to analyze Medicaid spending and utilization for people who use HCBS. We began by designing a methodology to identify HCBS users in Medicaid claims data, a necessary first step because of the limitations of the claims data. In designing our methodology, we learned from existing approaches such as those used by CMS and KFF. To contribute to the research community, we documented our review and comparison of existing approaches in an issue brief.

HCBS data. MACPAC analyzed utilization and spending not just for all HCBS users but by subpopulations of users to identify potential differences among them. We found that several subpopulations are the primary drivers of spending and utilization in HCBS. People with mental illness, SUD, or serious emotional disturbance (SED) account for 41.2 percent of users; older adults make up 31.3 percent; beneficiaries with intellectual or developmental disabilities (I/DD) or autism spectrum disorder (ASD) make up 24.5 percent, and individuals under age 65 with potentially disabling conditions account for 17.8 percent of users. Overall, we found that HCBS users, when compared to the Medicaid population, tend to be older, more likely to be in the blind or disabled eligibility group, and more likely to be dually eligible for Medicare or Medicaid. We shared these data at the December 2024 Commission public meeting and plan to publish these high-level findings in an issue brief. After that, we plan to use this foundational analysis to explore specific subpopulations at a more granular level, for example, to review potential differences in utilization and spending between subpopulations in HCBS as compared to institutional care. This work will result in multiple separate publications.

HCBS payment. To better understand how Medicaid HCBS payment policies are being used to support the HCBS workforce, MACPAC engaged a contractor to review state payment methods and examine the factors that affect the development of HCBS payment policies. As part of that work, the Commission convened a TEP in September 2024 to identify the factors that affect state decisions on HCBS payment rates including the use of standardized rate setting. We published a compendium of state Medicaid payment policies for HCBS under Section 1915(c), which also includes other authorities that states use to cover HCBS such as state plan options and Section 1115. In addition, we published a brief that described our findings from analysis of survey data from the National Core Indicators Aging and Disability (NCI-AD) Adult Consumer Survey. The survey assesses the experience of Medicaid beneficiaries who are age 65 and older and individuals between the ages of 18 and 64 with physical disabilities including health status, service utilization, and experience with HCBS.

HCBS access. In FY 2024, we conducted work to assess the timeliness of eligibility determinations for individuals who are not eligible for Medicaid on the basis of modified adjusted gross income (MAGI), such as people who are elderly or disabled. Our focus in FY 2024 was on eligibility levers states can use, such as presumptive eligibility, to streamline the eligibility determination process. In August, we published a compendium of state Medicaid eligibility policies affecting the timeliness of access to HCBS. In FY 2025, the Commission discussed how states develop provisional plans of care in Section 1915(c) waivers and the relatively low state uptake of this flexibility. The Commission made a recommendation directing the Secretary to issue guidance to states on how to use provisional plans of care, including policy and operational considerations, under Section 1915(c), Section 1915(i), Section 1915(k) and Section 1115 in the March 2025 report to Congress. The Commission will continue its work on timely access following publication of that report, as it moves to an analysis of how states administer level of care determinations for individuals who need HCBS.

HCBS waiver administration. We finalized a review of the various federal HCBS authorities that states use to administer their HCBS programs. States primarily use Section 1915(c) waivers and may operate multiple HCBS programs under various federal authorities. Our work explored the complexity for states of managing the varying requirements associated with the different HCBS authorities and looked for opportunities to streamline. We also interviewed stakeholders to obtain their insights on administrative complexity. Based on our findings, the Commission recommended extending the renewal period for Section 1915(c) waivers from five years to 10 years to reduce the administrative burden of more frequent renewals on states and the federal government. This policy change aligns with past practice where select Section 1115 demonstrations were renewed for 10 years. In addition, it is consistent with the standard 10-year budget window the Congressional Budget Office uses for developing budget projections and cost estimates. Our findings and recommendation appear in the March 2025 report to Congress.

We also have projects currently underway in FY 2025 related to HCBS, including a review of how states design and administer self-direction programs, barriers to program administration, and what the experience is like for beneficiaries who self-direct their care. To improve our understanding of how states design these models and the barriers that exist to effective program administration, we contracted with a vendor to conduct 33 interviews between September 2024 and January 2025 with federal and state officials, national subject matter experts, and stakeholders. We also convened a panel of experts for our December 2024 public meeting that included a beneficiary who self-directs his care, a family caregiver, a researcher, and a state representative. Our findings will be included in our June 2025 report to Congress. Finally, to contribute to the limited research available on people with I/DD, we are using survey data to analyze demographic characteristics of adults with I/DD by type of insurance coverage.

Identify policy levers to improve care and to create programmatic efficiencies for people who are dually eligible for Medicaid and Medicare across delivery systems

MACPAC completed a number of analyses in FY 2024 related to integrating Medicaid and Medicare coverage for the dually eligible population. We recognize that states are at different stages in these efforts with only about 20 percent of people dually eligible enrolled in integrated coverage in 2022.

State Medicaid Agency Contracts (SMACs). In FY 2024, we studied how states use the contracts that Medicare Advantage (MA) D-SNPs are required to sign with states, referred to as SMACs. That work built on a MACPAC examination of contracting strategies available to states to promote greater integration through their D-SNP contracts. Our latest analysis examined how states leverage SMACs to promote integration and the challenges states face to optimizing their SMACs. We also assessed how states make use of data and reporting requirements for D-SNPs, how they monitor and provide oversight of SMACs, and where state requirements have contributed the most to progress in integrating care. In the June 2024 report to Congress, the Commission recommended that states use their contracting authority at 42 CFR 422.107 to require that MA D-SNPs operating in their state regularly submit data on care coordination and MA encounters to the state for purposes of monitoring, oversight, and assurance that plans are coordinating care according to state requirements. If Congress requires states (as previously recommended by the Commission) to develop a strategy to integrate Medicaid and Medicare coverage for their dually eligible beneficiaries, states that include D-SNPs in their integration approach should describe how they will incorporate care coordination and utilization data and how these elements can advance state goals. The Commission also recommended that CMS update guidance that supports states in their development of a strategy to integrate care that is tailored to each state's health coverage landscape. The guidance should also emphasize how states that contract with D-SNPs can use their SMACs to advance state policy goals.

Program of All-inclusive Care for the Elderly (PACE). In FY 2024, MACPAC began new work examining PACE. Because most PACE enrollees are dually eligible beneficiaries, the program is of interest to the Commission as part of our effort to explore opportunities to improve care and create programmatic efficiencies for this population. Because this is a new area of analysis for MACPAC, our June 2025 report to Congress will include an overview of the program but is not expected to include recommendations. We envision additional analysis of PACE policy issues identified through our initial project work.

In FY 2025, MACPAC reviewed CMS rulemaking on Medicare Advantage that contained policies affecting dually eligible beneficiaries. This included a public discussion of a proposed rule for contract year 2026 and publication of a formal comment letter in January 2025.

Assess Medicaid and CHIP policy levers for addressing the behavioral health needs of beneficiaries

MACPAC continued its focus on behavioral health issues in FYs 2024 and 2025. This body of work included analyses of access to behavioral health services for children, youth, and adults.

Appropriate residential care for children. The Commission initiated a multi-year investment to examine access to the continuum of care for children with complex behavioral health care needs. This work is important not just because of the ongoing youth behavioral health crisis, but also because many of the children with these needs also experience challenges associated with being involved in the child welfare or juvenile justice systems. In our first phase of work, we are examining how Medicaid ensures that children who require residential care receive that care. This work will review federal policies governing coverage of residential treatment services, access to and use of these services, and challenges state face in providing them. We are also developing analytic work to understand federal and state quality and safety requirements for residential treatment facilities and what is known about facility performance. MACPAC also plans to assess access to home and community-based behavioral services, including, for example, high intensity wrap-around services, which can be helpful in supporting the care of children with intense behavioral health needs in their communities.

Transitions of care and coverage for children and youth with special health care needs. The Commission is examining the experience of children and youth with special health care needs and their caregivers when aging out of pediatric to adult systems of care. These beneficiaries have complex medical conditions that often result in permanent disabilities. MACPAC conducted a literature review, federal and state policy scans, stakeholder interviews, and beneficiary and caregiver focus groups to assess the policy framework for these transitions for this vulnerable group of beneficiaries, and to identify challenges and opportunities to address them. The Commission is poised to make recommendations to Congress and the HHS Secretary in the June 2025 report to Congress that would improve the availability of information for families about the transition of care process, make guidance available to states for covering and paying for transition services, ensure that data are collected to understand whether children and youth with special health care needs receive the transition services they need, and to improve interagency coordination.

In spring of 2025, MACPAC will begin the second phase of this work to assess transitions of coverage for the same population. When children and youth with special health care needs age out of children's coverage groups or child-only waivers, ensuring their transition to adult eligibility groups or adult waivers is important for preventing gaps in care which could have negative consequences for their health. This work will assess how federal and state Medicaid policy addresses transition to adult coverage categories or waivers for eligible children and youth with special health care needs. We will analyze eligibility and enrollment data to understand the number of children who are of transition age, how many transition to adult coverage, and if they experience coverage gaps. This work will continue into FY 2026.

Medicaid for children in the child welfare system. This work examines the role of Medicaid in providing coverage to children in the child welfare system, with a focus on children in foster care. MACPAC conducted a literature review and federal and state policy scan as well as numerous interviews with federal and state Medicaid and child welfare officials, researchers, and other stakeholders. Our work found that despite policy changes and federal and state efforts over several years, persistent issues related to interagency collaboration, data and information sharing, challenges in meeting the complex behavioral needs of children in foster care pose barriers to ensuring these beneficiaries receive the services they need. Our findings will be described in the June 2025 report to Congress. Given the complexity and persistent nature of these issues, we are planning further analyses, including an examination of the role of managed care organizations designed to serve children in foster care in ensuring access to care.

Medications for opioid use disorder. MACPAC is analyzing the effects of the federal mandate for Medicaid coverage of medication to treat opioid used disorder established in the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271). Through interviews and document review, this work will shed light on policy levers affecting access to treatment for opioid use disorder. This work includes a quantitative analysis of the prevalence of opioid use disorder-related deaths among Medicaid enrollees and the availability of outpatient treatment programs. We anticipate publishing our findings in the June 2025 report to Congress.

The Commission is also assessing what is being learned in state Section 1115 SUD demonstrations. Through these demonstrations, states are granted flexibility to provide beneficiaries short-term inpatient and residential treatment for SUD, including opioid use disorder. States are required to report to CMS on specified performance measures and milestones, including improved adherence to treatment and reduced use of emergency department and inpatient hospital settings. In the coming months, we will convene an expert panel discussion to share what is being learned and issues for consideration as these demonstrations continue.

School-based health services. Given the youth behavioral health crisis, MACPAC continued its examination of school-based behavioral health services for children and youth with Medicaid. This work assessed how Medicaid policies support children's access to behavioral health services in schools and what, if any, barriers impede such access. This analysis included a literature review and interviews with state Medicaid and education officials as well as other stakeholders. In March 2024, we published an issue brief on School-Based Services for Students Enrolled in Medicaid, which provided an overview of school-based services (SBS) (medically necessary services provided to children with disabilities with Medicaid coverage to support their public education), including federal actions to reduce administrative burden associated with SBS, factors affecting billing and claiming, and considerations for ensuring access to SBS. In 2024 we also began a second phase of our work on access to behavioral health services in school settings and are examining the role of school-based health centers in providing behavioral services to students. We published findings from this work in March 2025.

In FY 2025, we kicked off work looking at access to services in the community for children with disabilities who also receive services in school-settings under the requirements of the federal Individuals with Disabilities Education Act (IDEA, P.L. 101-476). Through this work we hope to understand whether children are being inappropriately denied medically necessary care, in both managed care and fee-for-service delivery systems, outside of school settings because they also receive services in schools, and policy levers to address concerns.

Oral health for individuals with I/DD. In FY 2023 and FY 2024, we undertook an analysis of access to oral health services by adults with intellectual and developmental disabilities that focused on their unique needs and considerations for providing this population dental services. Poor oral health is widespread among this population and they often face challenges in finding providers to serve them. We plan to issue a brief with findings in 2025.

Behavioral health data. We continue our effort to analyze administrative data (i.e., T-MSIS) to better understand utilization and spending for behavioral health services by Medicaid beneficiaries. We are currently assessing the quality of data to determine the feasibility of disaggregating the data by demographic factors.

Examine the effects of federal Medicaid and CHIP policies on enrollment in and renewal of coverage

Eligibility and enrollment. In FY 2024, we completed work assessing enrollment barriers for individuals with limited English proficiency (LEP) and Medicaid levers for addressing them. In 2021, there were approximately 25.7 million people with LEP in the United States, including almost 4.9 million Medicaid and State Children's Health Insurance Program (CHIP) enrollees. Those with LEP have poor health outcomes, including higher use of emergency departments and hospital readmissions, and a higher prevalence of conditions such as hypertension, asthma, and mental health diagnoses. In July 2024 we published our findings, including that availability of translated materials varied among states and document type, and that paper applications were more likely to be translated into non-English languages than electronic application portals.

COVID-19 and the PHE. In FY 2024, MACPAC maintained its focus on Medicaid and the COVID-19 pandemic, particularly the effects of the continuous coverage policy and its unwinding. We regularly engaged CMS, state Medicaid officials, policy researchers, and national and local beneficiary advocates and monitored state experience with the resumption of routine eligibility redeterminations. We also focused on the implications of the end of the continuous coverage provision for beneficiaries, some of whom would lose Medicaid coverage, and states, which faced an unprecedented volume of redeterminations while at the same time facing state workforce shortages. We convened numerous panels of state officials and stakeholders to share their plans and experiences with Commissioners. For example, these panel discussions addressed updates from states on their unwinding activities, challenges, and strategies to leverage managed care organizations to facilitate appropriate coverage renewals.

Beginning in FY 2024 and into FY 2025, the Commission shifted its focus from monitoring the unwinding of the PHE-era continuous coverage policy to what can be learned from the unwinding process and federal and state policy priorities in a post-PHE environment. In November 2024, we published an issue brief that summarized findings from our analysis of state-reported unwinding enrollment and eligibility metrics for Medicaid and CHIP. Specifically, this brief highlighted state performance for April 2023 to June 2024 on enrollment, disenrollment, renewals, program operations, and federally facilitated and state-based marketplaces. We also have work underway to analyze data from the Current Population Survey to understand sources of coverage (e.g., exchanges, uninsurance) for individuals who left Medicaid after the end of the PHE.

Additionally, in 2024, we began work to examine timely access to HCBS as described above. This work is looking at state use of flexibilities to implement policies and processes, including presumptive eligibility and provisional plans of care, to streamline Medicaid enrollment for non-MAGI individuals who need HCBS. During the PHE, CMS provided guidance to states on options to pursue temporary flexibilities related to the eligibility and service planning provisions of HCBS programs. This work resulted in a recommendation that CMS issue guidance on how states can use provisional plans of care in the March 2025 report to Congress.

Additional priority areas

Program integrity (PI). MACPAC continues to focus on ensuring that federal Medicaid dollars are used appropriately. In April 2024, Commissioner Tim Hill testified before the House Committee on Energy and Commerce Subcommittee on Oversight and Investigation on improper payments in Medicaid. Commissioner Hill's testimony focused on findings from prior MACPAC work on PI with a focus on opportunities to improve PI activities at the federal and state levels.

In FY 2024 and FY 2025, we continued to develop a body of work to examine policy levers available to states and CMS to hold Medicaid MCOs accountable for providing care to beneficiaries. Such levers include, for example, monitoring of denials and appeals and the EQR process. Our June 2024 report to Congress included a chapter and seven recommendations for improving denials and appeals processes. These recommendations address opportunities for greater monitoring and transparency around denials and appeals and to improve beneficiary trust in established processes. Our work on EQR analyzed how states use EQR to monitor and encourage improved MCO performance that culminated with a chapter in the March 2025 report to Congress. In FY 2024, we began work examining how CMS regulates state Medicaid agencies and ensures compliance with federal regulations, and how state Medicaid agencies oversee their contracted MCOs' performance and hold plans accountable.

In FY 2025, we kicked off work to examine how federal, state, and managed care organization policies ensure that only qualified providers can participate in Medicaid. Enrollment and credentialing policies and processes are designed to prevent state Medicaid agencies from paying claims from fraudulent providers and to avoid the need for programs to identify and recover those overpayments. However, some state Medicaid agencies and providers have noted that the provider enrollment and credentialing process can be a barrier to provider participation in Medicaid, thereby limiting access to care for enrollees. This work is expected to lay a foundation for future work assessing approaches for balancing the goals of ensuring program integrity and avoiding undue administrative burden.

Maternity care. In FY 2024 and 2025, MACPAC continued work to examine Medicaid's role in maternal health as poor maternal and infant health outcomes continue to rise, and significant disparities persist for pregnant women. In FY 2024, we examined screening and treatment of perinatal mental health among Medicaid beneficiaries. The quantitative component of this work analyzes data from the Postpartum Assessment of Health Survey to shed light on the prevalence of behavioral health conditions among people in the postpartum period. The qualitative analysis examined the services covered by states and barriers to access to them, which was published in an issue brief released in January 2025.

Justice-involved Medicaid beneficiaries. MACPAC's work to analyze pre-release services for youth in the juvenile justice system, which we began in FY 2024, continues. This work is in follow up to our 2023 analysis of access to Medicaid coverage and care for adults leaving incarceration. This chapter was especially well-timed with CMS's release of guidance on and work with states to approve Section 1115 demonstrations to provide pre-release services, and with legislative activity related to this issue. Our chapter identifies key considerations for providing Medicaid pre-release services.

Beneficiary engagement. The Commission's March 2024 report to Congress included a chapter on state Medicaid program use of statutorily required medical care advisory committees (MCACs) to engage beneficiaries. The chapter included the Commission's recommendations that CMS issue guidance to states for addressing beneficiary recruitment and engagement challenges, that states include provisions in the MCAC bylaws addressing recruitment of diverse beneficiaries, and that states develop and implement plans to facilitate beneficiary engagement and to reduce the burden on beneficiaries in participating in MCACs.

Communicating the results of our work

MACPAC's efforts to disseminate information about the Medicaid and CHIP programs continue to grow. In calendar year (CY) 2024 and in the first quarter of 2025, we produced three statutorily required reports to Congress, the *MACStats: Medicaid and CHIP Data Book*, 14 issue briefs, and one comment letter. In January 2024, MACPAC jointly produced with MedPAC a data book on beneficiaries who are dually eligible for Medicaid and Medicare. The Commission also published three policy briefs which are intended to provide short (one to two page) summaries of a key policy issue, MACPAC research findings, and if applicable, recommendations in an easily digestible format.

MACPAC's website continues to serve as an important resource for those seeking nonpartisan, evidence-based information on Medicaid. MACPAC updated its website in 2024 to make information more accessible and easier to find. In 2024 and 2025, traffic to our website remained steady from the prior year, with the site averaging about 30,000 visitors per month.

LinkedIn and X (formerly known as Twitter) are major vehicles to announce new publications and other updates. MACPAC created a LinkedIn account in 2021 and now has more than 5,500 followers. On X, MACPAC has more than 3,800 followers who include many influential health policy reporters, organizations, and researchers who often amplify our work. In addition, MACPAC launched a YouTube channel in late 2023 to provide resources and 101s on various topics in Medicaid.

MACPAC's mailing list has more than 4,400 subscribers, including key agency leadership and staff, members of Congress and staff, Medicaid directors and other state officials, health policy reporters, and policy organizations. Our mailing list has an average open rate of 51 percent and a click rate of 18 percent, which are higher than click and open rates in comparable industries.

Commission meetings

MACPAC held six public meetings in 2024 and three thus far in 2025, with a virtual viewing option, that allowed members of the public to participate remotely and watch the Commission deliberate in person, as well as offer public comment at selected points during the meeting. Meeting attendance during this time period has averaged about 483 registrants per meeting and reached a high of 592 registrants for the October 2024 meeting. These numbers far surpass typical attendance at in-person-only meetings, and the approach facilitates more people from the states to participate.

Consultation and coordination efforts

In FY 2024 and FY 2025, MACPAC continued its practice of obtaining perspectives from those with varied interests in Medicaid and CHIP policy.

Consultation with staff of committees of jurisdiction. We briefed key staff of our authorizing committees (Senate Finance and House Energy and Commerce) prior to each Commission meeting to preview all agenda items and sent all presentation materials as follow-ups. As is our customary practice, we invited authorizing committee staff to our annual planning retreat to relay and discuss their policy priorities with the full Commission. We also provided additional briefings on our work plan to ensure that staff are apprised of the Commission's ongoing and future streams of work. Congressional priorities are a key input into the Commission's policy work.

Consultation with state policy officials and state-focused associations. The Commission meets regularly with state Medicaid and CHIP officials and other state-focused associations to better understand state information and perspectives on emerging trends in the Medicaid and CHIP programs.

In addition, MACPAC staff were guest speakers at meetings of many of these organizations and participated in invitation-only expert roundtables. We also conducted listening sessions with CHIP directors in conjunction with the National Academy for State Health Policy annual meeting, state aging and disability directors during the ADvancing States conference, the National Association of State Directors of Developmental Disabilities Services, the National Association of State Mental Health Program Directors, and with the National Association of Medicaid Directors board of directors. We engaged with both state mental health program leaders to obtain their views and experiences with the priority behavioral health care issues and with state directors of developmental disabilities to hear about services and policies affecting access to behavioral health care for individuals with intellectual disabilities and developmental disabilities.

Moreover, MACPAC conducted structured interviews or otherwise engaged with officials in 38 states in 2024 as part of various research projects; some states participated in multiple projects.

Coordination and consultation with other federal health agency officials. In addition to working with the Centers for Medicaid and CHIP Services, the Medicare-Medicaid Coordination Office, and the Center for Medicare and Medicaid Innovation within CMS, MACPAC maintained strong working relationships with key staff in

the executive branch including the Agency for Healthcare Research & Quality, CDC, ASPE, the National Center for Health Statistics, SAMHSA, and HHS OIG. We also worked with other congressional support agencies including CBO, CRS, and GAO. These activities helped strengthen the quality of our work and reduce duplication of effort. For example, we conferred with GAO as they launched Medicaid studies. We also continued to ask relevant agency personnel to provide technical reviews of MACPAC products to ensure their accuracy.

Consultation with beneficiaries, providers, and other key stakeholders. The Commission recognizes that Medicaid and CHIP touch a broad array of other stakeholders including health plans, different types of providers (e.g., hospitals, physicians, home care agencies), and beneficiary advocates. We are pleased that meeting attendance is growing and that more organizations are offering public comments at our meetings, and in follow-up correspondence.

In FY 2024, MACPAC staff frequently met with representatives of stakeholder organizations, providing an opportunity for them to share their recent research findings, policy priorities, issue areas of concern, and potential data sources that could be available to support MACPAC analyses, and to review MACPAC's analytic agenda. Because such meetings help inform the Commission's work plans, research, and analytic agendas, we maintain an open-door policy, meeting with such groups as time permits, and value the effort and dedication of stakeholders who step forward to put public comments on the record at Commission meetings.

In addition, MACPAC staff made formal presentations at meetings sponsored by stakeholder organizations. Over the past year, in addition to the conferences of state-focused associations, staff have been featured speakers for organizations including AcademyHealth, AHIP, Alliance for Health Policy, American Hospital Association, American Society of Actuaries, Association of Community-Affiliated Health Plans, Health and Aging Policy Fellows, the Penn Leonard Davis Institute of Health Economics, and the MLTSS Association. MACPAC staff also participated in the State Health Access Data Assistance Center health equity advisory committee and the National Committee for Quality Assurance Public Sector Advisory Council.

Coordination with MedPAC and the Medicare-Medicaid Coordination Office on issues related to persons who are dually eligible for Medicare and Medicaid. In keeping with its statutory charge to collaborate and consult with MedPAC and the CMS Medicare-Medicaid Coordination Office, MACPAC leadership met quarterly with key contacts at MedPAC and the duals office. In addition, MedPAC and MACPAC staff collaborated formally in publishing the annual data book on dually eligible beneficiaries and informally by reviewing each other's products to ensure technical accuracy of work of mutual interest.

Technical assistance

MACPAC staff routinely respond to confidential technical assistance requests from staff of our authorizing committees as well as from the offices of other members interested in Medicaid and CHIP policy. Requests come from both chambers, and from both sides of the aisle.

In FY 2024, MACPAC staff responded to 34 requests for technical assistance. In FY 2025, staff have responded to multiple requests and have provided briefings to congressional staff. The volume of such requests suggests both a demand for information on Medicaid and CHIP as well as high confidence in MACPAC as a source of relevant data and policy analyses.

Many requests sought technical feedback on draft legislation or policy proposals. These include reviewing the potential effects of proposals, pointing out gaps, and noting needed cross references and citations to other relevant provisions of statute or regulation. The topics of such requests varied but the most frequent topics included DSH, maternal health, and behavioral health. We also received numerous requests for background or educational information on current Medicaid rules and policies, how programs have been implemented, and what is known about their effects, challenges, and other policy considerations. Recent requests of this nature focused on behavioral health, prescription drug coverage, LTSS, coverage of individuals dually eligible for Medicaid and Medicare, and maternal health. Finally, we responded to requests for data such as enrollment and spending in areas such as hospital and provider payment.

The level of staff time needed to respond to requests varied but often required input from several staff if, for example, draft legislation touches upon multiple aspects of Medicaid. For example, some maternal health

proposals addressed coverage, behavioral health, and telehealth. Similarly, some behavioral health proposals included provisions related to eligibility, coverage, and prescription drug policy.

Administrative and operational enhancement

In FY 2024, MACPAC modernized MACPAC meeting rooms with enhanced audio-visual technology, continuing our refresh of end-user and office hardware, and upgrading components of our network infrastructure. MACPAC streamlined hiring and recruitment functions by optimizing use of the most effective recruitment platforms and strengthened its partnership with service providers at GSA, promoting maximum efficiency in administrative operations.

In FY 2024, MACPAC retained the services of an attorney with health policy and Medicaid expertise to assist with legal research and provide consultation. MACPAC has applied these services in enhancing our analytic work (for example, with respect to statutory and regulatory authorities) and our agency operations (for example, through improvements to our procurement processes).

Appendix A. Commission Members and Terms

Verlon Johnson, MPA, Chair

Robert Duncan, MBA, Vice Chair

Term expires April 2026

Timothy Hill, MPA
American Institutes for Research
Columbia, MD

Carolyn Ingram, MBA
Molina Healthcare, Inc.
Santa Fe, NM

Patti Killingsworth
CareBridge
Nashville, TN

Adrienne McFadden, MD, JD
Elevance Health
Tampa, FL

Jami Snyder, MA
JSN Strategies, LLC
Phoenix, AZ

Term expires April 2027

Heidi L. Allen, PhD, MSW
Columbia University School of Social Work
New York, NY

Doug Brown, RPh, MBA
COEUS Consulting
Glen Allen, VA

Robert Duncan, MBA
Connecticut Children's – Hartford
Prospect, CT

Verlon Johnson, MPA
Acentra Health
Olympia Fields, IL

John B. McCarthy, MPA
Speire Healthcare Strategies
Nashville, TN

Michael Nardone, MPA
The Nardone Group
Philadelphia, PA

Term expires April 2028

Sonja L. Bjork, JD
Partnership HealthPlan of California
Fairfield, CA

Jennifer L. Gerstorff, FSA, MAAA
Mercer
Seattle, WA

Angelo P. Giardino, MD, PhD, MPH
The University of Utah
Salt Lake City, UT

April Hartman, MD, FAAP
Augusta University
Augusta, GA

Dennis Heaphy, MPH, MEd, MDiv
Massachusetts Disability Policy Consortium
Boston, MA

Anne Karl, JD
Manatt Health
New York, NY

Appendix B. Biographies of Commissioners

Heidi L. Allen, PhD, MSW, is an associate professor at Columbia University School of Social Work, where she studies the impact of social policies on health and financial well-being. She is a former emergency department social worker and spent several years in state health policy, examining health system redesign and public health insurance expansions. In 2014 and 2015, she was an American Political Science Association Congressional Fellow in Health and Aging Policy. Dr. Allen is also a standing member of the National Institutes of Health's Health and Healthcare Disparities study section. Dr. Allen received her doctor of philosophy in social work and social research and a master of social work in community-based practice from Portland State University.

Sonja L. Bjork, JD, is the chief executive officer of Partnership HealthPlan of California (PHC), a non-profit community-based Medicaid managed care plan. Before joining PHC, Ms. Bjork worked as a dependency attorney representing youth in the child welfare system. During her tenure at PHC, she has overseen multiple benefit implementations and expansion of the plan's service area. Ms. Bjork served on the executive team directing the plan's $280 million strategic investment of health plan reserves to address social determinants of health. These included medical respite, affordable housing, and substance use disorder treatment options. Ms. Bjork received her juris doctor from the UC Berkeley School of Law.

Doug Brown, RPh, MBA, is senior vice president of value and access at COEUS Consulting, with more than 30 years of pharmacy management experience. Mr. Brown provides executive level health care consulting and market access support services to life science companies and health care organizations, including the development of value- and outcomes-based contracting strategies with state Medicaid programs, pharmacy benefit administrators, manufacturers, and the Centers for Medicare & Medicaid Services. Prior to joining COEUS in 2020, he served in several roles for Magellan Rx Government, including as the chief strategy officer. While at Magellan, he led preferred drug list management for more than half the state Medicaid programs in the country, provided subject matter expertise on federal and state government legislation that impacted state Medicaid programs and offered policymakers a national view of evolving events in Medicaid. Mr. Brown is a registered pharmacist and holds a bachelor of science in pharmacy from the University of Rhode Island and a master's of business administration from Virginia Commonwealth University.

Robert Duncan, MBA, (Vice Chair), is chief operating officer of Connecticut Children's – Hartford. Before this, he served as executive vice president of Children's Wisconsin, where he oversaw the strategic contracting for systems of care, population health, and the development of value-based contracts. He was also the president of Children's Community Health Plan, which insures individuals with BadgerCare Plus coverage and those on the individual marketplace, and Children's Service Society of Wisconsin. He has served as both the director of the Tennessee Governor's Office of Children's Care Coordination and the director of the Tennessee Children's Health Insurance Program, overseeing the state's efforts to improve the health and welfare of children across Tennessee. Earlier, he held various positions with Methodist Le Bonheur Healthcare. Mr. Duncan received his master of business administration from the University of Tennessee at Martin.

Jennifer L. Gerstorff, FSA, MAAA, is a partner and consulting actuary at Mercer, where she focuses on Medicaid and other government programs. Over the course of her consulting career, she has served as lead actuary for several state Medicaid agencies. In addition to supporting state agencies through her consulting work, Ms. Gerstorff actively volunteers with the Society of Actuaries and American Academy of Actuaries workgroups, participating in research efforts, developing content for continuing education opportunities, and facilitating monthly public interest group discussions with Medicaid actuaries and other industry experts. She received her bachelor in applied mathematics from Columbus State University.

Angelo P. Giardino, MD, PhD, MPH, is the Wilma T. Gibson Presidential Professor and chair of the Department of Pediatrics at the University of Utah's Spencer Fox Eccles School of Medicine and chief medical officer at Intermountain Primary Children's Hospital in Salt Lake City, Utah. Before this, Dr. Giardino worked at Texas Children's Health Plan and Texas Children's Hospital from 2005 to 2018. He received his medical degree and doctorate in education from the University of Pennsylvania, completed his residency and fellowship training at the Children's Hospital of Philadelphia, and earned a master of public health from the University of Massachusetts. He also holds a master in theology from Catholic Distance University and a master in public administration from the University of Texas Rio Grande Valley.

April Hartman, MD, FAAP, is a board-certified general pediatrician with over 25 years of clinical experience in both rural and urban settings. She serves as professor and division chief of general pediatric and adolescent medicine at the Medical College of Georgia at Augusta University. She currently chairs the Medicaid Task Force for the Georgia Chapter of the American Academy of Pediatrics; serves as president of the Board of Directors for Child Enrichment, Inc.; and is the medical liaison for Resilient Communities of East Georgia. Dr. Hartman earned her medical degree from Meharry Medical College in Nashville, Tennessee.

Dennis Heaphy, MPH, MEd, MDiv, is a health justice advocate and researcher at the Massachusetts Disability Policy Consortium, a Massachusetts-based disability rights advocacy organization. He is also a dually eligible Medicaid and Medicare beneficiary enrolled in One Care, a plan operating in Massachusetts under the CMS Financial Alignment Initiative. Mr. Heaphy is engaged in activities that advance equitable whole person–centered care for beneficiaries in Massachusetts and nationally. He is cofounder of Disability Advocates Advancing Our Healthcare Rights (DAAHR), a statewide coalition in Massachusetts. DAAHR was instrumental in advancing measurable innovations that give consumers voice in One Care. Examples include creating a consumer-led implementation council that guides the ongoing development and implementation of One Care, an independent living long-term services and supports coordinator role on care teams, and an independent One Care ombudsman. Previously, he worked as project coordinator for the Americans with Disabilities Act for the Massachusetts Department of Public Health (MDPH) and remains active on various MDPH committees that advance health equity. In addition to policy work in Massachusetts, Mr. Heaphy is on the advisory committee of the National Center for Complex Health & Social Needs and the Founders Council of the United States of Care. He is a board member of Health Law Advocates, a Massachusetts-based nonprofit legal group representing low-income individuals. He received his master of public health and master of divinity from Boston University and master of education from Harvard University.

Timothy Hill, MPA, is senior vice president at the American Institutes for Research (AIR), where he leads AIR's health division. Before joining AIR, Mr. Hill held several executive positions within the Centers for Medicare & Medicaid Services (CMS), including as a deputy director of the Center for Medicaid and CHIP Services, the Center for Consumer Information and Insurance Oversight, and Center for Medicare. Mr. Hill earned his bachelor's degree from Northeastern University and his master's degree from the University of Connecticut.

Carolyn Ingram, MBA, is an executive vice president of Molina Healthcare, Inc., which provides managed health care services under the Medicaid and Medicare programs as well as through state insurance marketplaces. Ms. Ingram is also the plan president for Molina Healthcare of New Mexico and the executive director of the Molina Healthcare Charitable Foundation. Previously, Ms. Ingram served as the director of the New Mexico Medicaid program, where she launched the state's first managed long-term services and supports program. She also held prior leadership roles, including vice chair of the National Association of Medicaid Directors and chair of the New Mexico Medical Insurance Pool. Ms. Ingram earned her bachelor's degree from the University of Puget Sound and her master of business administration from New Mexico State University.

Verlon Johnson, MPA, is executive vice president and chief strategy officer at Acentra Health, a Virginia-based health information technology firm that works with state and federal agencies to design technology-driven products and solutions that improve health outcomes and reduce health care costs. Ms. Johnson previously served as an associate partner and vice president at IBM Watson Health. Before entering private industry, she was a public servant for more than 20 years, holding numerous leadership positions, including associate consortium administrator for Medicaid and CHIP at CMS, acting regional director for the U.S. Department of Health and Human Services, acting CMS deputy director for the Center for Medicaid and CHIP Services (CMCS), interim CMCS Intergovernmental and External Affairs group director, and associate regional administrator for both Medicaid and Medicare. Ms. Johnson earned a master of public administration with an emphasis on health care policy and administration from Texas Tech University.

Anne Karl, JD, is a partner at Manatt Health with 15 years of experience in health care. She advises states and providers across the country on a wide range of Medicaid and CHIP issues. Ms. Karl has expertise with complex Medicaid payment and financing issues. She also leads teams that support states as they develop, negotiate, and implement Medicaid 1115 waivers. Ms. Karl received her law degree from Yale Law School.

Patti Killingsworth is the senior vice president of long-term services and supports (LTSS) strategy at CareBridge, a value-based healthcare company dedicated to supporting Medicaid and dually eligible beneficiaries receiving home- and community-based services. Ms. Killingsworth is a former Medicaid beneficiary and lifelong family caregiver with 25 years of Medicaid public service experience, most recently as the longstanding assistant

commissioner and chief of LTSS for TennCare, the Medicaid agency in Tennessee. Ms. Killingsworth received her bachelor's degree from Missouri State University.

Michael Nardone, MPA, currently leads an independent consulting practice providing strategic advice on Medicaid health policy and long-term services and supports. He has extensive experience in leading health and human services programs at the state, local, and national levels, most recently as director of the Disabled and Elderly Health Programs Group at the Center for Medicaid and CHIP Services. Mr. Nardone previously led the Pennsylvania Department of Human Services as Acting Secretary and was the state's Medicaid director, serving on the executive committee of the National Association of Medicaid Directors. After leaving Pennsylvania state government, he joined Health Management Associates (HMA) as a managing principal and led establishment of the HMA Harrisburg office. He also served as the city of Philadelphia's deputy managing director for special needs housing and has held government relations positions for the Commonwealth of Massachusetts and the University of Pennsylvania Health System. Mr. Nardone received a master's degree in public affairs from the Princeton School of Public and International Affairs.

John B. McCarthy, MPA, is a founding partner at Speire Healthcare Strategies, which helps public and private sector entities navigate the health care landscape through the development of state and federal health policy. Previously, he served as the Medicaid director for both the District of Columbia and Ohio, where he implemented a series of innovative policy initiatives that modernized both programs. He has also played a significant role nationally, serving as vice president of the National Association of Medicaid Directors. Mr. McCarthy holds a master's degree in public affairs from Indiana University's Paul H. O'Neill School of Public and Environmental Affairs.

Adrienne McFadden, MD, JD, is vice president and chief medical officer of Medicaid at Elevance Health, where she serves as the strategic clinical thought leader for the Medicaid line of business. After beginning her career in emergency medicine, Dr. McFadden has held multiple executive and senior leadership roles in health care, digital health and public health. Dr. McFadden received her medical and law degrees from Duke University.

Jami Snyder, MA, is the president and chief executive officer of JSN Strategies, LLC, where she provides health care–related consulting services to a range of public and private sector clients. Previously, she was the Arizona cabinet member charged with overseeing the state's Medicaid program. During her tenure, Ms. Snyder spearheaded efforts to stabilize the state's health care delivery system during the public health emergency and advance the agency's Whole Person Care Initiative. Ms. Snyder also served as the Medicaid director in Texas and as the president of the National Association of Medicaid Directors. Ms. Snyder holds a master's degree in political science from Arizona State University.

Appendix C. Commission Public Meetings and Major Agenda Items

April 10 – 11, 2025

- Medicaid in Context: Key Statistics and Trends
- Medicaid in Context: Payment and Financing
- Children and Youth with Special Health Care Needs (CYSHCN): Transitions of Care
- Timely Access to Home- and Community-Based Services: Level of Care Determinations and Person-Centered Planning Processes
- Access to Medications for Opioid Use Disorder in Medicaid
- Understanding the Program of All-Inclusive Care for the Elderly (PACE) Model
- Self-Direction for Medicaid Home- and Community-Based Services
- Panel on Automation and Artificial Intelligence in the Prior Authorization Process
- Medicaid Payment Policies to Support the Home- and Community-Based Services Workforce: Policy Considerations
- Health Care Access for Children in Foster Care: Study Findings
- Appropriate Access to Residential Treatment for Behavioral Health Needs for Children in Medicaid
- Medicare-Medicaid Plan Transition: Procurement, Information Technology, and Enrollment

February 27 – 28, 2025

- Draft Policy Recommendations to Improve Transitions of Care for Children and Youth with Special Health Care Needs
- Hospital Non-DSH Supplemental Payment and Directed Payment Targeting Analyses
- Overview of the Self-Directed Model
- Interview Findings on Self-Direction Program Design and Administration
- Improving Access to Medications for Opioid Use Disorder Themes from Stakeholder Interviews
- Panel: Substance Use Disorder Section 1115 Demonstrations
  - Cindy Beane, MSW, LCSW, Medicaid Director, West Virginia Bureau for Medical Services
  - Henry Lipman, MBA, Medicaid Director, New Hampshire Division of Medicaid Services
  - John O'Brien, National Advisor, Manatt Health
- Automation in the Prior Authorization Process
- Health Care Access for Children in Foster Care
- Appropriate Access to Residential Services for Children and Youth with Behavioral Health Needs: Interview Findings

January 23 – 24, 2025

- Timely Access to Home- and Community-Based Services
- Home- and Community-Based Services Payment Policy Option
- Utilization of Medications for Opioid Use Disorder in Medicaid

- Panel: Appropriate Access to Residential Services for Children and Youth with Behavioral Health Needs
  - Gary Blau, PhD, Executive Director Emeritus at The Hackett Center and Senior Fellow for Children's Mental Health at the Meadows Mental Health Policy Academy
  - Maureen Corcoran, MSN, MBA, Medicaid Director, Ohio Department of Medicaid
  - Steven Girelli, PhD, President and CEO of Klingberg Family Centers
  - Ivy-Marie Washington, Project Associate, American Public Human Services Association
- Examining the Role of External Quality Review in Managed Care Oversight and Accountability
- Medicaid Section 1915 Authorities for Home- and Community-Based Services: Analyzing Federal Administrative Requirements and Opportunities to Streamline
- Children and Youth with Special Health Care Needs: Transitions from Pediatric to Adult Care Policy Options
- Understanding the Program of All-Inclusive Care for the Elderly Model: Interviews with Key Stakeholders

December 12 – 13, 2024

- State and Federal Tools for Ensuring Accountability of Medicaid Managed Care Organizations
- External Quality Review (EQR) Draft Recommendations
- Transitions of Care for Children and Youth with Special Health Care Needs (CYSHCN): Policy Considerations and Options
- Potential Areas for Comment on CMS Proposed Rule on Medicare Advantage (MA) for CY2026
- Self-Directed Services in Medicaid Home- and Community-Based Services (HCBS)
- Panel: Self-Direction for HCBS
  - Patricia Brennan, Director of the Office of Education on Self-Directed Services, Priority Waiting List, and Special Projects, New Jersey Division of Developmental Disabilities
  - Mark Sciegaj, PhD, MPH, Professor of Health Policy and Administration, the Pennsylvania State University
  - Pamela Zotynia, Certified Supports Broker and Service Director, Values into Action
  - Robert Zotynia, Self-direction Participant
- Timely Access to HCBS: Policy Option on Provisional Plans of Care
- HCBS Spending and Utilization
- Findings from a Technical Expert Panel on Medicaid Payment Policies to Support the HCBS Workforce
- Highlights from the 2024 Edition of MACStats

October 31 – November 1, 2024

- Medications for Opioid Use Disorder and Related Policies
- Timely Access to Home- and Community-Based Services: Provisional Plans of Care
- Panel: Multi-Year Continuous Eligibility for Children
  - Cindy Mann, JD, partner at Manatt Health
  - Emma Sandoe, PhD, MPH, Medicaid director with the Oregon Health Authority
  - Laura Barrie Smith, PhD, senior research associate in the Health Policy Center at the Urban Institute
- Youth Use of Residential Treatment Services: Federal and State Findings
- Managed Care External Quality Review Policy Options
- Transitions of Care for Children and Youth with Special Health Care Needs (CYSHCN): Interview and Focus Group Findings
- Directed Payments in Medicaid Managed Care

September 19 – 20, 2024

- Overview of Recently Published Final Rules
- Timely Access to Home- and Community-Based Services (HCBS): Use of Presumptive Eligibility and Expedited Eligibility for Non-Modified Adjusted Gross Income (MAGI) Populations
- Section 1915 Medicaid Home- and Community-Based Services Authorities: Revisiting Policy Options
- Understanding the Program of All-Inclusive Care for the Elderly (PACE) Model: Background and Panel Discussion
  - Cindy Proper, PACE Technical Director within the Division of Health Homes, PACE and COB/TPL in the Medicaid Benefits and Health Programs Group, Center for Medicaid and CHIP Services
  - Kayla King, PACE and Senior Care Options (SCO) Program Manager at the MassHealth Office of Long-Term Services and Supports
  - Sabrena Lea, Deputy Director for Long-Term Services and Supports (LTSS) in the North Carolina Department of Health and Human Services, Division of Health Benefits
- Introduction to Work on Residential Services for Youth with Behavioral Health Needs
- Managed Care External Quality Review (EQR)
- Introduction to Work on Justice-Involved Youth
- Themes from Hospital Payment Index Technical Expert Panel (TEP)

Appendix D. Upcoming Meetings

Remainder of Fiscal Year 2025

June 12-13, 2025 (Retreat)

September 18-19, 2025

Fiscal Year 2026

October 30-31, 2025

December 11-12, 2025

January 29-30, 2026

March 5-6, 2026

April 9-10, 2026

June 11-12, 2026 (Retreat)

September 24-25, 2026

Fiscal Year 2027

October 29-30, 2026

December 10-11, 2026

January 28-29, 2027

March 4-5, 2027

April 15-16, 2027

June 10-11, 2027

September 16-17, 2027

Appendix E. Publications

This list includes all MACPAC products published since the submission of our last budget justification in March 2024.

Reports to Congress

- Report to Congress on Medicaid and CHIP (March 2025)
  - Examining the Role of External Quality Review in Managed Care Oversight and Accountability
  - Timely Access to Home- and Community-Based Services
  - Streamlining Medicaid Section 1915 Authorities for Home- and Community-Based Services
- Report to Congress on Medicaid and CHIP (June 2024)
  - Improving the Transparency of Medicaid and CHIP Financing
  - Optimizing State Medicaid Agency Contracts
  - Medicare Savings Programs: Enrollment Trends
  - Medicaid Demographic Data Collection
- Report to Congress on Medicaid and CHIP (March 2024)
  - Engaging Beneficiaries through Medical Care Advisory Committees to Inform Medicaid Policymaking
  - Denials and Appeals in Medicaid Managed Care
  - Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States

Data books

- MACStats: Medicaid and CHIP Data Book (December 2024)

Issue briefs

- Access in Brief: Children's Experiences in Accessing Medical Care (April 2025)
- School-based Health Centers and Behavioral Health Care for Students Enrolled in Medicaid (March 2025)
- Access in Brief: Postpartum Mental Health in Medicaid (January 2025)
- Evaluating the Effects of Medicaid Payment Changes on Access to Physician Services (January 2025)
- State Reported Medicaid Unwinding Data (November 2024)
- Directed Payments in Medicaid Managed Care (October 2024)
- Methodological Approaches for Analyzing Use and Spending in Medicaid Long-Term Services and Supports: A Comparative Review (August 2024)
- Access in Brief: Seniors and Adults with Physical Disabilities (August 2024)
- Access in Brief: Children and Youth with Special Health Care Needs (August 2024)
- Prior Authorization in Medicaid (August 2024)
- Enrollment and Access Barriers for People with Limited English Proficiency (July 2024)
- Medicaid Base and Supplemental Payments to Hospitals (May 2024)
- School-Based Services for Students Enrolled in Medicaid (March 2024)
- Access in Brief: Effects of COVID-19 on Medicaid Beneficiaries' Health and Health Care Utilization (March 2024)

Policy brief

- Alternative Approaches to Federal Medicaid Financing (April 2025)
- State Options to Address Medicaid Spending Growth (April 2025)
- Medicaid Eligibility Policies Affecting the Timeliness of Home- and Community-Based Services (August 2024)

State policy compendia

- Compendium: Medicaid Eligibility Policies Affecting the Timeliness of Access to Home- and Community-Based Services (August 2024)