Budget Justification

Justification of Appropriations Request for the Committee on Appropriations for Fiscal Year 2027

April 2026

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Justification of Appropriations Request Fiscal Year 2027

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.

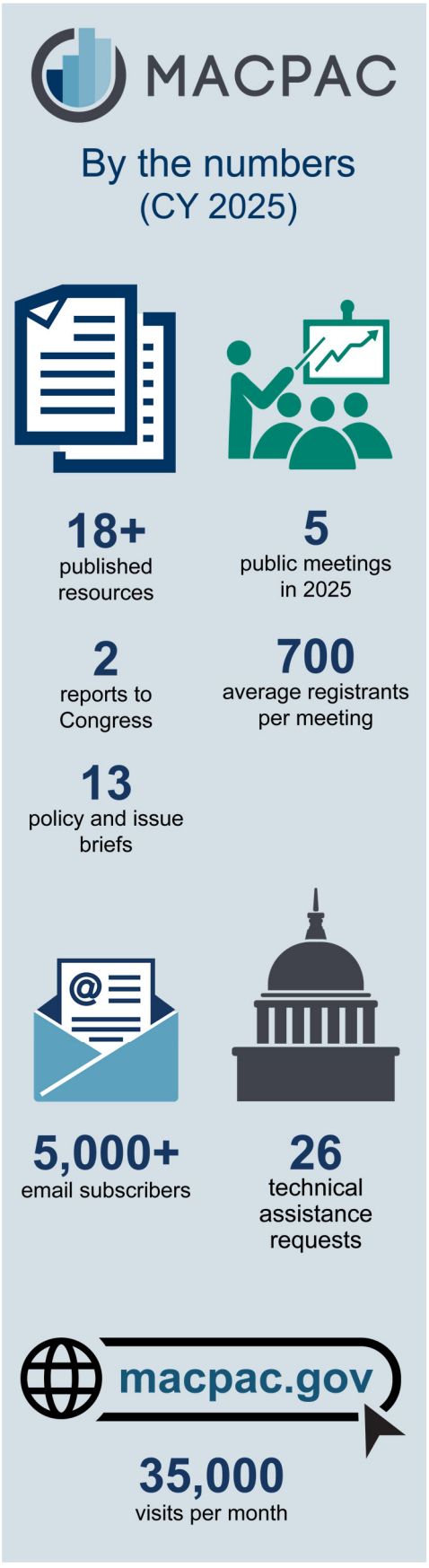
The Commission's authorizing statute, Section 1900 of the Social Security Act, requires that it submit reports to Congress by March 15 and June 15 of each year. The statute also outlines a number of areas for analysis, including:

- 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) 2027.



Key Research and Activities for Fiscal Year 2027

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. Differences in how states design and operate Medicaid and CHIP create unique challenges to data and policy analysis and the development of federal policy and 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), financing and payment policies (e.g., provider supplemental payments), spending on prescription drugs, maternal health, integrating care for beneficiaries eligible for both Medicare and Medicaid, 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 2027 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, and accountability and transparency in program operations and outcomes.

Below we describe the activities MACPAC will undertake in FY 2027 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, program integrity, integrating care for dually eligible beneficiaries, HCBS as an alternative to care in nursing facilities, Medicaid payment and financing, and prescription drug policy. 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 included, 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 an 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. 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. We have devoted staff resources to understanding the nuances of the data and any quality or validity issues, and documenting these for internal and external use.

  We invested in our analytic capabilities to facilitate deeper analysis of HCBS and behavioral health services. We conducted analyses of 2019–2021 T-MSIS data that resulted in an issue brief providing HCBS utilization and spending data by LTSS subpopulation and taxonomy. 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. During this report cycle, we published findings from our 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 2027, 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 2027. 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 700 participants each meeting. MACPAC welcomes public comment both in writing (at any time) and through dedicated timeslots at each public Commission meeting. In CY 2025, MACPAC received nearly 30 submissions of public comment, 12 in writing and 15 in our five public meetings. Those submitting public comments represent organizations and interests from across the country, including state Medicaid agencies, national associations, and individual members of the interested public. These comments spoke to a wide range of issues before the Commission, including HCBS, accountability in Medicaid managed care, and services for children and youth with special health care needs (CYSHCN).

Importantly, the hybrid format has enabled Medicaid stakeholders from across the country, including beneficiaries and advocates, to participate and offer their experience on the program. In the last year, Commission meeting panelists included provider representatives, beneficiary advocates and an enrollment assister in Georgia. 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 2025 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 2027, 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 2027, 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 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*, the *New York Times,* the *Wall Street Journal*, and the *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, Paragon Institute, 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 that are educational and provide timely evidence to inform Medicaid and CHIP discourse. In FY 2027, 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 IT architecture to improve office infrastructure, enhance cybersecurity, implement new workflow management tools, and operate our website. In FY 2027, we will also continue routine updates of end-user and network hardware.

During FY 2027, 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) 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 2025 appropriation. This is the same amount as requested for FYs 2025 and 2026.

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.

Finally, high-quality data analysis has been a central focus in MACPAC's commitment to conducting policy analysis of the highest caliber. In 2027, MACPAC must undergo changes in its vendor contracts supporting our quantitative analytic work, and these changes occur against a backdrop of changes to data management policies and processes occurring at CMS. Our primary goal is maintaining analytic capacity and research quality, but we project this will demand data analytic funding support in excess of our appropriations to date.

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. Beginning in FY 2025, the agency operated within its annual appropriation alone. We seek an annual appropriation adequate to fund MACPAC's statutory charge given that no year funds are no longer available (Exhibit 1).

MACPAC has not received an increase to our annual appropriations since FY 2023, which will soon prompt changes to our analytic activities and agency operations. On average, MACPAC engages in over 40 analytic projects under contract annually, which include data analyses, qualitative interviews, and expert and beneficiary focus groups. The average annual cost of these activities has increased from FY 2022 to FY 2025 by about 2 to over 4 percent, depending on the type of analysis. Additionally, salaries and expenses consume close to 65 percent of our annual appropriation. While MACPAC has been able to accommodate these price increases and other inflationary pressures for four years, the agency is challenged by our size and the amount of fixed costs in our budget to continue without considering adjustments.

MACPAC is committed to making prudent decisions with its available resources. Our FY 2027 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 2018–2027

Fiscal year	Appropriation requested	Funds appropriated	No year funds available[1]	Total available funding[2]
2018[1]	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[2]	9,727,000	9,405,000	573,354	9,978,354
2024[3]	10,053,000	9,405,000	565,354	9,970,354
2025[4]	10,698,000	9,405,000	–	9,405,000
2026[5]	10,698,000	9,405,000	–	9,405,000
2027	10,698,000			

Notes:

– Dash indicates not yet available.

[1] 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.

[2] 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.

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

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

[5] MACPAC received funding under the Consolidated Appropriations Act, 2026 (P.L. 119-75).

FY 2026 Appropriation. In the below exhibits we reflect our actual and projected expenses for MACPAC's FY 2026 appropriation. Some of these reflect unusual spending patterns for MACPAC because of the government shutdown in October and November 2026. The shutdown impacted our public meeting schedule and related expenditures, including Commissioner travel, stipends, and other expenses.

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 2027. 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 2025–2027 (thousands of dollars)

Category	FY 2025 actual expenses	FY 2026 appropriation	FY 2027 request	Change from FY 2026 to FY 2027 request
Salaries and benefits	$5,703	$6,063	$6,519	7.5%
Non-personnel costs	3,696	3,342	4,179	25.0
Total	**$9,399**	**$9,405**	**$10,698**	**13.7%**

Notes: FY is fiscal year.

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. 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.

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 2025 actual	FY 2026 appropriation	FY 2027 request	Change from FY 2026 to FY 2027
11.1	Permanent staff	$3,936	$4,244	$4,421	4.2% [1]
11.3	Other than permanent: Commissioners and internships	252	206	281	36.4 [2]
12	Personnel benefits	1,515	1,613	1,816	12.6 [3]
Subtotal, personnel		**5,703**	**6,063**	**6,519**	**7.5**
21	Travel	145	87	145	66.7 [4]
23	Rent, utilities, and communications	559	401	583	45.4 [5]
24	Printing and reproduction	7	7	7	0.0
25	Research contracts and data analysis services	2,217	2,000	2,561	28.1 [6]
25	Other contractual services	623	675	702	4.0 [7]
26	Supplies and materials	68	56	90	60.7 [8]
31	Equipment purchases	77	116	91	-21.6 [9]
Subtotal, non-personnel		**3,696**	**3,342**	**4,179**	**25.0**
TOTAL		**$9,399**	**$9,405**	**$10,698**	**13.7%**

Notes: FY is fiscal year.

[1] Due to recent staff turnover, MACPAC's FY 2026 projection does not include full-year salary expenses for vacant positions projected as filled in the FY 2027 request.

[2] The FY 2026 projection for this budget line reflects reduced stipend payments for Commissioners in FY 2026, compared to FY 2025 actual expenses and FY 2027 projections, due to the impacts of the 2026 government shutdown on the MACPAC meeting schedule.

[3] The increase in personnel benefits includes increases in benefit costs for staff in FY 2027.

[4] The FY 2026 projection for this budget line reflects sharply decreased travel for Commissioners in FY 2026, compared to FY 2025 actual expenses and FY 2027 projections, primarily related to the government shutdown.

[5] The FY 2026 projection for this budget line reflects rental credits and other savings MACPAC will recognize in FY 2026. FY 2027 costs are projected to align with FY 2025 incurred expenses.

[6] The increase in this budget line is attributable to unavoidable increased costs in data security and management contracts.

[7] The increase in other contractual services in both FY 2026 and FY 2027 is attributable to increases in IT advisory services related to necessary software deployments and upgrades.

[8] The increase in supplies and materials is due to required, planned purchases of IT system components.

[9] The FY 2026 and FY 2027 projections include planned upgrades of IT system components.

MACPAC is 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 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 and regulations.

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. Increasing vendor costs are evident in both our research and core operations contracts. MACPAC must reprocure essential data management contractual services, and we expect those costs to increase substantially in FY 2027. The agency is also implementing a multi-year equipment upgrade and reconfiguration process that strengthens our IT security posture while streamlining software procurements. These equipment and software updates ensure that staff have secure, reliable technology needed to conduct the agency's work, and are consistent with industry practice for IT security.

Our request for FY 2027 for travel supporting in-person meetings returns to pre-shutdown levels. MACPAC canceled the October 2025 public meeting, and shifted to virtual, not in-person attendance, for the December public meeting due to the government shutdown. The travel line item primarily reflects spending on travel for Commissioners and a modest amount of staff travel to professional meetings and site visits. Over time, we have 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.

In FY 2027, MACPAC budgets staffing at 34 full-time equivalents to support our considerable analytic agenda (Exhibit 4). Staff turnover requires 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 2023–2027

Fiscal year	Budgeted full-time equivalents
2023	33
2024	33
2025	34
2026	34
2027	34

Legislative Language Request

EXHIBIT 5. FY 2027 Appropriations Language

> For expenses necessary to carry out section 1900 of the Social Security Act, $10,698,000.

Exhibit 5 represents MACPAC's appropriations language that reflects our FY 2027 requested amount.

In October 2024, 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. We greatly appreciate that MACPAC was granted the latter through the Consolidated Appropriations Act, 2026.

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] 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.

> (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.

We advance this request in coordination with the Medicare Payment Advisory Commission. As similarly structured Commissions, we jointly identified the need for this legislative flexibility.

Activities and Outcomes in Fiscal Years 2025-2026

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 2025, CMS implemented aspects of several MACPAC recommendations related to enrollment, beneficiary engagement, and payment transparency:

Behavioral health. The Commission recommended that the Secretary of HHS direct CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA), to issue joint subregulatory guidance that addresses how Medicaid and CHIP can be used to fund a crisis continuum for beneficiaries experiencing behavioral health crises. In September 2025, CMS and SAMHSA issued a state health official letter on the continuum of crisis services and how states can support implementation of this continuum through Medicaid and CHIP.

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

[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

publish their evaluation reports, and further noted CMS's intent to make state evaluation results available on Medicaid.gov.

Key MACPAC accomplishments and activities since the submission of our last budget request (FY 2025 and to date in FY 2026) 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 2025 and 2026 include:

- examining the relationship between physician payment and access to care, challenges in data collection and research in Medicaid, and opportunities for future research on the relationship between Medicaid payment and 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;
- examining 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 and starting new work to understand the key drivers of hospital cost;
- assessing programmatic and policy considerations related to the implementation of Medicaid community engagement requirements;
- 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;
- conducting an analysis of access to covered oral health services for adult Medicaid beneficiaries with intellectual and developmental disabilities;
- conducting an examination of appropriate access to residential treatment for behavioral health for individuals with complex care needs and who need that level of care;
- beginning an analysis of policy levers available to CMS and states to ensure that youth with complex behavioral health needs can be served and remain in the community and to reduce inappropriate use of residential treatment services;
- researching state Medicaid and managed care organization (MCO) utilization management policies for medications for opioid use disorder (MOUD) to understand how the policies enable states and plans to manage costs while ensuring appropriate and timely access to MOUD;
- comparing enrollment of dually eligible beneficiaries in Medicare Advantage dual eligible special needs plans (D-SNPs) with that of enrollment in chronic condition SNPs (C-SNPs) and institutional SNPs (I-SNPs);
- exploring the extent to which states have the authority and capacity to establish, monitor and enforce standards in the Program of All-Inclusive Care for the Elderly (PACE) and the extent to which they can measure and evaluate quality of care provided to PACE participants receiving integrated care in 33 states and the District of Columbia;
- identifying and describing the demographic characteristics of PACE enrollees;

- exploring recommendations for improving HCBS rate setting and payment rates;
- exploring Medicaid coverage of assistive technology (AT), with a focus on adults using HCBS, and how AT might be a tool for independence for individuals that could potentially lessen the burden on the HCBS workforce;
- understanding how self-direction operates under the broader Medicaid HCBS assurances for beneficiary health and welfare and assessing whether CMS and states need additional assurances to protect the health and welfare of beneficiaries self-directing their HCBS;
- conducting analyses of federal Medicaid program integrity (PI) levers to support state PI efforts and whether any barriers to such activities can be addressed by policy change;
- beginning an examination of federal, state, and MCO Medicaid provider enrollment and credentialing policies to understand how they ensure that only qualified providers can participate in Medicaid and how the policies may affect providers' willingness to participate in Medicaid; 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

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 2025, MACPAC published an issue brief on directed payments in Medicaid managed care that had been approved as of August 1, 2024. The issue brief highlighted recent trends in the number of directed payments and the projected spending amount tied to these arrangements. We presented new information on directed payment arrangements using separate payment terms, as the 2024 managed care rule will eliminate this option in 2027.

We began work to update the fee for service (FFS) inpatient hospital payment index that was published in 2017. Building on findings from a technical expert panel (TEP) including states, federal officials, payment experts, and researchers, we refined and updated the methodology to incorporate new data sources (e.g., T-MSIS, FFS supplemental payment report) as well as new payment arrangements such as state directed payments. 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.

To supplement the hospital payment index analysis, we have started work to examine the drivers of Medicaid hospital costs, how states account for them in the development of hospital payment policies, and what policy strategies states use to respond to these cost drivers. This work will include a compendium of hospital payment policies and stakeholder interviews on how states consider hospital costs when developing and updating payment rates.

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 has 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. Although MACPAC does not have specific project work on cell and gene therapies or other prescription drug policies for this work cycle, we are monitoring developments in this space.

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. We are continuing a 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.

- **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 includes 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 examined 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 conducted 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. Our research found that states generally felt that they had sufficient tools to oversee managed care plans, but additional guidance or toolkits on how to structure effective procurement and sanction processes could be helpful.

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 been investigating the role of automation in the Medicaid prior authorization process and how managed care plans, states, and the federal government oversee its use. We presented the findings in FY 2026.

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

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 published these high-level findings in an issue brief in July 2025. We are using 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. We plan to publish additional findings in FY 2026.

HCBS payment. To better understand how Medicaid HCBS payment policies are being used to support the HCBS workforce, MACPAC has examined HCBS payment rate setting over multiple reporting cycles. We found ultimately that an opportunity to improve states' rate setting activities existed in possible improvements to the availability of historic HCBS worker wage data.

HCBS access. After publishing 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 in FY 2026, as it moves to an analysis of how states administer level of care determinations for individuals who need HCBS.

Self-direction. In FY 2025 we began 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. Our initial findings were included in a 2025 report to Congress. In FY 2026, we are continuing this work to focus on beneficiary health and welfare. Findings will be included in our March 2027 report to Congress.

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

In FY 2024, MACPAC focused on integrated care for dually eligible beneficiaries in different integrated coverage options including D-SNPs and Medicare-Medicaid Plans (MMPs).

MMP monitoring. We have largely wrapped up our work on the MMP transition, as states began enrollment in new plans January 1, 2026. We are exploring ways to track the movement of beneficiaries from MMPs to integrated D-SNPs for a defined period of time and conclude our work with a description of those movements.

SNP analysis. In FY 2026, we plan to continue our work on policies affecting dually eligible beneficiaries by examining enrollment of dually eligible beneficiaries in Medicare Advantage C-SNPs and I-SNPs. We will compare enrollment in these plans to enrollment in D-SNPs. We will also explore available data on utilization and spending on Medicaid coverage in C-SNPs and I-SNPs.

PACE. In FY 2025, MACPAC continued examining PACE. After publishing our descriptive work in the June 2025 report to Congress, we came back to the topic with a focus on the extent to which states have the authority to establish, monitor, and enforce standards as well as to measure and evaluate quality for PACE beneficiaries. We plan to include our findings in the June 2026 report to Congress. We are also conducting a data analysis of the demographic characteristics of PACE enrollees, which we plan to share publicly as well, most likely in a standalone brief.

CMS rulemaking. Every year, MACPAC reviews CMS rulemaking on the new Medicare Advantage contract year to the extent that it contains policies affecting dually eligible beneficiaries. This typically includes a public discussion of a proposed rule and publication of a formal comment letters. MACPAC submitted a formal comment letter on the latest CMS rulemaking related to MA contract year 2027.

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

MACPAC continued its focus on behavioral health issues in FYs 2025 and 2026. This body of work included analyses of access to behavioral health services for children, youth, and adults.

Appropriate access to behavioral health services for children. The Commission continued its multi-year investment to examine access to the continuum of care for children with complex behavioral health care needs, including appropriate access to residential treatment and access to community-based behavioral health services. 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 multi-system involvement (e.g., 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 reviews federal policies governing coverage of residential treatment services, access to and use of these services, and challenges state face in providing them. We plan to publish a chapter with our findings in the June 2026 report to Congress, and anticipate making policy recommendations. We are also developing the next component of our analytic work on residential care, which will examine federal and state quality and safety requirements for residential treatment facilities, what is known about facility performance, and the policy levers available to address concerns or challenges. MACPAC has started work 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. This work will continue into FY 2027.

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, and challenges meeting the complex behavioral needs of children in foster care pose barriers to ensuring these beneficiaries receive the services they need. Our findings were included in the March 2026 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. In 2025, MACPAC convened an expert panel discussion to share what is being learned and issues for consideration as Section 1115 SUD demonstrations continue. 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.

MACPAC analyzed the effects of the federal mandate for Medicaid coverage of medication to treat opioid used disorder (MOUD) established in the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271). Our June 2025 report to Congress describes findings from our work regarding policy levers affecting access to treatment for opioid use disorder, state coverage of MOUD, and factors creating barriers to MOUD access. This work also included a quantitative analysis of the use of MOUD, including the use of specific medications. Our work examining access to MOUD continues, with a project analyzing state use of utilization management (UM) approaches and how UM is being used to ensure access to appropriate MOUD. This work includes a quantitative analysis of how changes in UM practices can affect certain outcomes including treatment continuity, opioid overdose rates, and opioid-related emergency department visits. This analysis will continue into FY 2027.

School-based health services. Given the youth behavioral health crisis, MACPAC has examined school-based behavioral health services for children and youth with Medicaid. Following up on previously published work, in FY 2025, we published a brief on access to behavioral health services in school settings, including the role of school-based health centers in providing behavioral services to students.

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). This work is focusing on what can be learned about Medicaid-covered children and youth with individualized education plans (IEPs) and individualized family service plans (IFSPs) using data from the National Survey of Children's Health. Our analysis will assess beneficiary demographic characteristics, health conditions, and access to health coverage and services for those with IEPs and IFSPs.

Oral health for individuals with I/DD. In June 2025, we issued a brief describing findings from our work examining access to oral health services by adults with intellectual and developmental disabilities. Our analysis focused on the unique needs and considerations for providing dental services to this population. Poor oral health is widespread among individuals with intellectual and development disabilities, who often face challenges in finding providers to serve them.

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 use of and spending on behavioral health services for children and adults in calendar year 2023. The objective of the analysis is to estimate the prevalence of certain behavioral health conditions and utilization of and spending on behavioral health services stratified by certain enrollee demographic characteristics, behavioral health conditions, and selected care settings (e.g., inpatient, outpatient, or residential settings).

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

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. The Commission made 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 about 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 a second phase of this work, MACPAC is assessing 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 assesses 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 analyzed 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 be published in the June 2026 report to Congress.

Children's eligibility. Given the role that Medicaid plays in covering low-income children, we convened a panel discussion on how states use continuous eligibility (CE), including multi-year CE, to reduce enrollment churn

among children, a long-standing concern for CMS, states, policymakers, and other stakeholders. Panelists shared their expert insight on the policy and operational considerations for implementing CE and the research and data needed to understand the effects of the CE on children's coverage and health outcomes.

In FY 2026, we plan to begin work assessing considerations and options for the future of CHIP funding. CHIP is currently funded through FY 2029, and it is the Commission's intent to offer policy recommendations to inform congressional deliberation on the future of CHIP funding. This will work continue into FY 2027.

Community engagement requirements. With the enactment of Medicaid community engagement requirements in July 2025, we incorporated research on this new policy into our analytic work plan. In September 2025, we convened a panel of experts to discuss the major considerations for implementing the new law in a relatively short timeframe. Experts discussed technology needs and challenges, beneficiary outreach and education considerations, and the need for timely federal guidance. In December 2025, we convened another panel, which included leadership from CMS and the National Association of Medicaid Directors, for a detailed discussion of federal and state implementation considerations and needs. The panel also discussed lessons from the COVID-19 public health emergency unwinding that could inform CMS and state efforts. Our work on community engagement will continue into FY 2027.

HCBS eligibility. In FY 2025, we completed our examination of timely access to HCBS. This work looked 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 FY 2025 and FY 2026, 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. 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. Additionally, 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. Our work includes a review of federal and state provider enrollment policies and approaches, and interviews with stakeholders to understand their experience with them. We plan to share our findings in the June 2026 report to Congress.

Additionally, we started a new body of work in program integrity to review the different roles and responsibilities for the federal government, states and territories, and managed care plans. As a part of this work, we held listening sessions with stakeholder organizations to identify key issues, that warrant further examination and monitoring. For example, the listening sessions highlighted the complex program oversight structure that requires assistance and coordination across multiple levels of federal and state government. We plan to start work during FY 2026 to better understand how the federal government can assist states to carry out their program integrity functions.

Maternity care. MACPAC has continued work to examine Medicaid's role in maternal health; poor maternal and infant health outcomes continue to rise and significant disparities persist for pregnant women. In January 2025, we issued a brief on state Medicaid program coverage of perinatal mental health screening and treatment services and barriers to accessing them. The brief included findings from our analysis of data from the Postpartum Assessment of Health Survey on the prevalence of behavioral health conditions among people in the postpartum period. We are currently exploring the feasibility of updating our Access in Brief on Pregnant Women

and Medicaid with the latest release of the national Pregnancy Risk Assessment Monitoring System (PRAMS) data. PRAMS combines survey data with birth certificate data to describe maternal characteristics, behaviors, and experiences.

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 built on our 2023 analysis of access to Medicaid coverage and care for adults leaving incarceration. We synthesized the considerations for states as they work to implement juvenile justice-related pre-release services and the status of state efforts in the March 2026 report to Congress.

Data coordination. Early in FY 2026, we began examining the need for and challenges with cross-agency data coordination and sharing, an issue which has surfaced in multiple MACPAC analytic projects. We are considering the feasibility of developing a framework or common set of principles to inform state Medicaid and other agency efforts to facilitate the efficient sharing of data, as well as opportunities for policy recommendations. This work is in nascent stages and will continue into FY 2027.

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) 2025, we produced two statutorily required reports to Congress, 15 additional published resources, and one comment letter. In December 2025, MACPAC jointly produced with MedPAC a data book on beneficiaries who are dually eligible for Medicaid and Medicare.

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 2025, traffic to our website increased from the prior year, with the site averaging about 35,000 visitors per month. Newly in 2025, MACPAC posted plain language versions of selected issue briefs to broaden the accessibility of our publications.

LinkedIn continues to be a major channel to announce new publications and share other updates. MACPAC now has more than 6,400 followers. MACPAC launched a YouTube channel in late 2023 to provide resources and 101s on various topics in Medicaid, with many of our videos generating more than 1,000 views.

MACPAC's mailing list has more than 5,000 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 17 percent, which is higher than click and open rates in comparable industries.

Commission meetings

MACPAC held five public meetings in 2025 and two thus far in 2026, 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. The October 2025 meeting was canceled due to the government shutdown. Meeting attendance during this time period has averaged about 700 registrants per meeting and reached a high of 937 registrants for the December 2025 meeting. These numbers surpass prior year figures and far exceed typical attendance at in-person-only meetings, as our hybrid approach facilitates participation nationwide.

Consultation and coordination efforts

In FY 2025 and FY 2026, 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 for Program Integrity, the National Association of Medicaid Fraud Control Units, and with the National Association of Medicaid 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 26 states in 2025 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 2025, 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 ADvancing States, America's Health Insurance Plans (AHIP), Alliance for Health Policy, Got Transition and the Lucile Packard Foundation, the Healthcare Financial Management Association, the Michigan State Senate Appropriations Subcommittee, the University of Michigan Center for Health Research and Transformation, the Non-Emergency Medical Transportation Accreditation Commission, and the Special Needs Plan (SNP) Alliance. 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 at least quarterly with key contacts at MedPAC and continued to coordinate with 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 2025, MACPAC staff responded to 28 requests for technical assistance. Thus far in FY 2026, 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. 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. The topics of TA requests varied but the most frequent topics included Medicaid financing, coverage of individuals dually eligible for Medicaid and Medicare, hospital payment, prescription drug coverage, and behavioral health.

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 behavioral health proposals included provisions related to eligibility, coverage, and prescription drug policy.

Administrative and operational enhancement

In FY 2025, MACPAC continued its updates to 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.

Continuing a contract initiated in FY 2024, MACPAC retains 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
Columbia, MD

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

Patti Killingsworth
Imagine Pediatrics
Nashville, TN

Adrienne McFadden, MD, JD
Elevance Health
Tampa, FL

Jami Snyder, MA
JSN Strategies, LLC
Santa Fe, NM

Term expires April 2027

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

Doug Brown, RPh, MBA
Red Nucleus
Manakin Sabot, 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, 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. Prior to 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 for the purpose of addressing social determinants of health. These included medical respite, affordable housing, and substance use disorder treatment options. Ms. Bjork received her Juris Doctorate from the UC Berkeley School of Law.

Doug Brown, RPh, MBA, is senior vice president of value and access at Red Nucleus, 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 executive vice president and chief operating officer of Connecticut Children's – Hartford. Prior to 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 also is 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. Previously, he 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. Prior to this, Dr. Giardino worked at Texas Children's Health Plan, Inc. 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's in theology from Catholic Distance University and a master's in public administration from 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 LTSS 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 Care Needs, Founders Council of the United States of Care, and 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 an experienced health policy executive. He has 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 plan president and senior 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. 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 the Centers for Medicare & Medicaid Services (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 a senior consultant for government strategy at Imagine Pediatrics. She is a former Medicaid beneficiary and lifelong family caregiver with 25 years of Medicaid public service experience. Previously, she served 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 healthcare 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

March 5 – 6, 2026

- Automation in the Medicaid Prior Authorization Process: Policy Options
- State and Federal Tools for Ensuring Accountability of Medicaid Managed Care Plans: Draft Recommendations
- Appropriate Access to Residential Services for Children and Youth with Behavioral Health Needs: Draft Policy Options
- Children and Youth with Special Health Care Needs (CYSHCN) Transitions to Adult Coverage: Draft Recommendations
- Exploring the Role of the State Medicaid Agency in the Program of All-Inclusive Care for the Elderly: Interview Findings
- Provider Enrollment and Credentialing in Medicaid
- Mandatory and Optional Enrollment and Spending in Medicaid
- Highlights from the February 2026 Edition of MACStats

January 29 – 30, 2026

- State and Federal Tools for Ensuring Accountability of Medicaid Managed Care Organizations: Policy Options
- Appropriate Access to Residential Services for Children and Youth with Behavioral Health Needs: Draft Policy Options
- Considerations for Implementing Community Engagement Requirements: Principles and Policy Option
- Children and Youth with Special Health Care Needs Transitions to Adult Coverage: Policy Options
- Medicaid Payment Policies to Support the Home- and Community-Based Services (HCBS) Workforce
- Behavioral Health in Medicaid and the State Children's Health Insurance Program
- Medicaid for Justice-Involved Youth Transitions to the Community
- Automation in the Prior Authorization Process: Findings
- Exploring the Role of the State Medicaid Agency in the Program of All-Inclusive Care for the Elderly (PACE): Program Agreement and Waiver Findings
- Federal Policy Framework for Beneficiary Health and Welfare in Self-Directed Home- and Community-Based Services (HCBS)

December 11, 2025

- Children and Youth with Special Health Care Needs (CYSHCN) Transitions to Adult Coverage: Data Findings
- CYSHCN Transitions to Adult Coverage: Interview Findings
- Considerations for Implementing Community Engagement Requirements: Findings from Stakeholder Interviews
- Expert Panel on Implementing Community Engagement Requirement
  - Caprice Knapp, Principal Deputy Director, Center for Medicaid and CHIP Services
  - Lindsey Browning, Deputy Executive Director, National Association of Medicaid Directors
- Expert Panel on Implementing Community Engagement Requirements: Additional Commission Discussion

- State and Federal Tools for Ensuring Accountability of Medicaid Managed Care Organizations (MCOs)

September 18 – 19, 2025

- Summary of P.L. 119-21, An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14
- Background on Work Related to Medicaid for Justice-Involved Youth
- Background on Work and Community Engagement Requirements in Medicaid
- Panel on Work and Community Engagement Requirements in Medicaid
  - Melisa Byrd, Senior Deputy Director, DC Department of Health Care Finance
  - Jessica Kahn, Partner, McKinsey & Company
  - Jennifer Strohecker, Medicaid Director, Integrated Healthcare Division, Utah Department of Health and Human Services
  - Deanna Williams, Enrollment Assister, Georgians for a Healthy Future
- Medicaid Payment Policies to Support the Home- and Community-Based Services (HCBS) Workforce: Draft Recommendation

  Background on Behavioral Health in Medicaid and the State Children's Health Insurance Program Children and Youth with Special Health Care Needs Coverage Transitions: Federal and State Policy Scan Finding
- Health Care Access for Children in Foster Care
- Background on Work Related to Medicaid for Justice-Involved Youth
- Implementation of Increased Federal Medical Assistance Percentage for HCBS under the American Rescue Plan Act: Key Takeaways
- Medicare-Medicaid Plan Transition

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
  - Sanmi Koyejo, PhD, Associate Professor, Stanford University Department of Computer Science and Principal Investigator, Stanford Trustworthy AI Research
  - Heather McComas, PharmD, Director, Administrative Simplification Initiatives, American Medical Association
  - Wayne Turner, JD, Senior Attorney, National Health Law Program
- 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

Appendix D. Upcoming Meetings

Remainder of Fiscal Year 2026

April 9-10, 2026

May 7, 2026

June 4-5, 2026 (Commission 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 (Commission Retreat)

September 16-17, 2027

Fiscal Year 2028

October 28-29, 2027

December 9-10, 2027

January 27-28, 2028

March 9-10, 2028

April 20-21, 2028

June 15-16, 2028 (Commission Retreat)

September 14-15, 2028

Fiscal Year 2029

October 26-27, 2028

December 7-8, 2028

January 25-26, 2029

March 8-9, 2029

April 19-20, 2029

June 14-15, 2029 (Commission Retreat)

September 20-21, 2029

Appendix E. Publications

This list includes all MACPAC products published since January 2025.

Reports to Congress

- Report to Congress on Medicaid and CHIP (March 2026)
  - Medicaid Payment Policies to Support the Home- and Community-Based Services Workforce
  - Behavioral Health in Medicaid and the State Children's Health Insurance Program
  - Medicaid for Justice-Involved Youth Transitions to the Community
  - Access to Care for Medicaid-Enrolled Youth in Foster Care
- Report to Congress on Medicaid and CHIP (June 2025)
  - Children and Youth with Special Health Care Needs Transitions of Care
  - Appropriate Access to Residential Behavioral Health Treatment for Children in Medicaid
  - Access to Medications for Opioid Use Disorder in Medicaid
  - Understanding the Program of All-Inclusive Care for the Elderly
  - Self-Direction for Home- and Community-Based Services
- 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

Data books

- MACStats: Medicaid CHIP Data Book (February 2026)
- Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid (December 2025)

Comment Letters

- Medicaid Program Integrity (March 2026)
- Proposed Rule on Policy and Technical Changes to Medicare Advantage for Contract Year 2027 (January 2026)
- Proposed Rule on Policy and Technical Changes to Medicare Advantage for Contract Year 2026 (January 2025)

Issue briefs

- Mandatory and Optional Enrollees and Services in Medicaid (March 2026)
- Implementation of the American Rescue Plan Act: Additional Support for Medicaid Home- and Community-Based Services during the COVID-19 Emergency (January 2026)
- Rate Setting for Medicaid Home- and Community-Based Services (August 2025)
- Medicaid Financing (August 2025)
- Spending and Utilization for Medicaid Home- and Community-Based Services (July 2025)
- Access in Brief: Adults' Experiences in Accessing Medical Care (July 2025)
- Access to Dental Services for Adults with Intellectual and Developmental Disabilities (June 2025)

- Access in Brief: Differences in Demographics and Access to Care by Source of Health Coverage for Adults with Intellectual and Developmental Disabilities (June 2025)
- 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)

Policy briefs

- State Medicaid Payment Policies for Medicare Cost Sharing (August 2025)
- Alternative Approaches to Federal Medicaid Financing (April 2025)
- State Options to Address Medicaid Spending Growth (April 2025)

State policy compendia

- Compendium: State Medicaid Payment Policies for Medicare Cost Sharing (August 2025)
- Inventory of Evaluations of Integrated Care Programs for Dually Eligible Beneficiaries (February 2025)