CHAMBER HILL

INSIGHTS

Select Sessions from MACPAC April Meeting: Community Engagement Requirements, Program Integrity, and Votes on Recommendations

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On April 9 and 10, 2026, the Medicaid and CHIP Payment and Access Commission (MACPAC) met for their April meeting. The Commissioners held sessions on implementing community engagement requirements in Medicaid and on Medicaid program integrity. Commissioners also voted in favor of 2 reccomendations related to Medicaid managed care to be included in the June 2026 report to Congress.

IMPLEMENTING COMMUNITY ENGAGEMENT REQUIREMENTS IN MEDICAID

MACPAC staff began the session by providing an overview of the previous research completed on the community engagement requirements, including expert panel and stakeholder interviews that were conducted in the summer of 2025. Staff then presented the draft recommendation that will be voted on during the May 2026 meeting, for inclusion in the June 2026 report to Congress. The draft recommendation reads: "The Secretary of the US Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to develop a transparent plan for monitoring and evaluating community engagement requirements in Medicaid that provides insight into how such policies affect eligibility and enrollment, health status, employment, state and federal administrative spending, and the attainment of other identified policy goals. CMS should identify new metrics for state reporting, as needed, and build upon existing data collection activities to minimize administrative burden. Additionally, CMS should ensure timely publication of monitoring and evaluation results to inform policy and operational decision making."

Commissioners appreciated the content and tone of the draft chapter, noting that the topic requires considerable detail. In general, the Commissioners indicated support for the draft recommendation but had some concerns about implementation.

For example, Commissioners raised concerns about the additional administrative burden that could be placed on states due to monitoring and evaluation requirements. Commissioners commented that state Medicaid agencies lack the ability to track health insurance enrollment and health status once a beneficiary leaves the program. Commissioners did note that it is easier to track the health and insurance status of beneficiaries who continually enter and exit the program because data such as their use of preventive care, emergency department care, and health insurance coverage is often available from the time they were not enrolled in Medicaid. Overall, Commissioners felt it was important for the recommendation to be realistic about what data can be captured and not recommend beyond what is possible.

Many Commissioners also felt it would be important to evaluate the cost-effectiveness of community engagement requirement implementation, specifically understanding how much states are spending versus saving. Commissioners highlighted costs associated with the accelerated implementation timeline and the likely increase in uncompensated care, especially in rural communities that serve a higher percentage of Medicaid beneficiaries.

Commissioners also discussed a few other topics. One Commissioner highlighted the need to track the reason an individual becomes disenrolled after the work requirements are implemented, especially to understand if it is an administrative error and the individual is still eligible. Another Commissioner questioned whether there were platforms that could evaluate participation in nontraditional employment, such as gig work, as Equifax, one of the highlighted platforms, does not have that capability. MACPAC staff shared that beneficiaries could use an income verification service but that they are not currently aware of additional platforms to recommend. Commissioners and MACPAC staff agreed that new platforms may have become available since data was collected, and so additional research would be beneficial. Lastly, a Commissioner requested that staff include more literature on the effects of increased administrative burden on patients, specifically how it leads to higher rates of health insurance disenrollment. MACPAC staff agreed that including literature about the topic could be beneficial and said they would review possible inclusions.

INTRODUCTION TO MEDICAID PROGRAM INTEGRITY

This session began with MACPAC staff providing an overview of program integrity and fraud, waste, and abuse within Medicaid. Staff then discussed the roles and responsibility of federal and state departments in program integrity and outlined the current issues in Medicaid program integrity. Key takeaways from the presentation included:

- Known fraud, waste, and abuse accounts for a small portion of program spending and its scale and impact are difficult to measure.
- Federal government, states, and health plans have a significant number of statutory and regulatory program integrity responsibilities.
- Key issues in program integrity include federal-state collaboration and program integrity in managed care.

Staff requested that the Commissioners provide feedback on the policy scan findings and further areas for exploration during stakeholder interviews.

Commissioners widely praised the material presented and appreciated the clear definitions and examples of fraud, waste, and abuse. Multiple Commissioners expressed the view that often the terms are inaccurately used, pointing out that disagreeing with a policy or statute does not constitute fraudulent or wasteful spending.

Commissioners had a wide variety of topics of interest for further exploration. A few Commissioners were interested in understanding how CMS and states decide where to invest money and time to best prevent program integrity issues and recover improper payments. One Commissioner specifically requested a return on investment analysis to understand where to invest to produce the best results. There was also widespread interest in understanding best practices for preventing fraud, recovering payments, and working with state Medicaid agencies.

Some other areas of interest included measuring the quality of State Medicaid Fraud Control Units, understanding how prior authorization is useful for program integrity, the impact of delays in convictions during fraud investigations for states, and ways to improve collaboration between CMS and states.

VOTE ON RECOMMENDATIONS FOR JUNE REPORT TO CONGRESS

Commissioners voted on 2 recommendations related to ensuring accountability of Medicaid managed care plans for inclusion in the June 2026 report to Congress.

The first recommendation reads, "The Secretary of the US Department of Health and Human Services should direct the Centers for Medicare and Medicaid Services to provide guidance on the types of accountability actions, such as liquidated damages, informal interventions, and other accountability actions, taken in response to plan noncompliance, in the sanctions section of the Managed Care Program Annual Report pursuant to 42 CFR 438.66(e)(2)(viii)." This recommendation passed by a vote of 17 to 0.

The second recommendation reads, "The Secretary of the US Department of Health and Human Services should direct the Centers for Medicare and Medicaid Services to develop a publicly available database on managed care plan performance that links federally mandated reported data together to facilitate analysis. CMS should also issue guidance and toolkits to help states effectively use these data to assess past performance, improve beneficiary experience, and oversee managed care plans." This recommendation passed by a vote of 17 to 0.

There was no discussion about either of the recommendations.

We trust you found this summary useful. Please reach out to us with any questions.