

INSIGHTS

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MACPAC September
Meeting: Community
Engagement Requirements,
SDPs, and Inpatient
Hospital Index

Select Sessions from MACPAC September Meeting: Community Engagement Requirements, SDPs, and Inpatient Hospital Payment Index

On September 24, 2026, the Medicaid and CHIP Payment and Access Commission (MACPAC) [held](#) its first meeting of the 2026-2027 cycle. During the meeting, MACPAC held sessions on implementing Medicaid community engagement (CE) requirements established under the One Big Beautiful Bill Act (OBBBA). This included an expert panel on how states are preparing for the January 1, 2027 implementation deadline. Commissioners then participated in a session to review two proposed Centers for Medicare and Medicaid Services (CMS) rules to implement changes to state-directed payments (SDPs) and provider taxes made by the OBBBA. Commissioners then discussed the current plan for updating the Inpatient Hospital Payment Index.

COMMUNITY ENGAGEMENT REQUIREMENTS IN MEDICAID: INTERIM FINAL RULE AND MONITORING FRAMEWORK

The session began with MACPAC staff reviewing the Commission's prior work on CE, including a recommendation in the June 2026 Report to Congress directing CMS to monitor and evaluate the requirements. Staff then summarized the key provisions of the interim final rule with comment period (IFC), which outlined how CMS plans to implement the CE requirements. Staff next reviewed updates since the IFC's release, including resources CMS has published since June, current lawsuits challenging aspects of the rule, and MACPAC's monitoring framework, focusing on state readiness, medical frailty, beneficiary outreach, and federal and state reporting.

Expert Panel

The panel featured Jack Rollins, Director of Federal Policy at the National Association of Medicaid Directors (NAMd), and Laura Saunders, Associate Principal at Health Management Associates (HMA). Both described 2027 as an iterative year in which state policies and operations will continue to evolve. Neither panelist was aware of any state actively pursuing a good faith exemption, and most states are planning for a January 1 start.

When asked about medical frailty frameworks, Mr. Rollins said the [CMS slide deck](#) has been a helpful illustration, particularly its emphasis on ex parte verification (without verification from the individual) and

on checking frailty only after considering if they are covered by other exclusions that are easier to verify. Ms. Saunders said at least a couple of states have already adopted a three-tier approach based on the CMS deck's example framework. Under that framework, Tier 1 covers conditions where ICD-10 diagnosis codes confirm a significant impairment, Tier 2 covers conditions that need additional utilization or functional data to confirm severity, and Tier 3 covers individuals without enough data, who are sent to manual review. Other states are building on the medical frailty processes they use for alternative benefit plans. She described the latter as a half-step head start given the narrower CE definition. Of the four states that have released condition lists, all but Montana published specific diagnosis codes acceptable for the medical frailty exemption. Ms. Saunders also said many states will rely heavily on self-attestation and manual processes in 2027 as a temporary workaround while systems are built out.

Both panelists described the administrative strain of implementing CE alongside six-month redeterminations, changes to retroactive coverage, and October 1 changes to federal matching funds for certain immigrant populations. Ms. Saunders noted that many of the same eligibility workers are also focused on SNAP error rates ahead of new penalties, and she expects more notices, longer processing times, and more procedural terminations. States are drawing on lessons from the unwinding of the COVID-19 continuous enrollment provision, including text messaging, county-by-county roadshows led by Medicaid officials, CE web pages, and online screening tools. Ms. Saunders cautioned that many enrollees identify with their managed care plan rather than Medicaid and may not know they are in the expansion group, which could make it difficult for enrollees to understand that the new requirements apply to them. She also said providers remain unsure of their role, which will matter more for medical frailty documentation once self-attestation narrows in 2028.

When asked where states still need clarification before January 1, Mr. Rollins pointed to the following:

- Final state plan amendment templates and data reporting templates, both already available in draft through the Paperwork Reduction Act process
- More detail on the good faith effort exemption process
- Guidance on notices for short-term hardship exceptions, especially the two that require the individual to take action
- Continued attention to how CE interacts with other eligibility changes
- Clarity on future audit expectations, including how CE will be incorporated into the Payment Error Rate Measurement (PERM) program ahead of statutory changes in fiscal year 2030

Ms. Saunders added that new guidance that shifts direction would be of limited help this late, but additional example models and assurances that good faith decisions will not jeopardize future federal funding would be valuable. Mr. Rollins noted that much of the detailed guidance is moving through a weekly NAMD-convened call between states and CMS that averages more than 300 state staff.

Commissioner Discussion

Commissioners had a number of questions for the panelists. One Commissioner asked what protections exist for states and providers that make good faith decisions in 2027 that are later questioned in audits. Mr. Rollins said states are documenting their decisions, including correspondence with CMS and internal process manuals, so they can show what they understood the policy to be at a given point in time. Ms. Saunders added that self-attestations are made under penalty of perjury.

Another Commissioner asked a series of questions about state choices under the IFC. Ms. Saunders said most states she has tracked are adopting all of the short-term hardship exceptions, though three or four are not. Few states are choosing longer look-back periods, and she had not seen any longer than three months. On verification, education data from the National Student Clearinghouse will be available through the Federal Data Services Hub, while community service verification remains largely manual. When asked how MACPAC could support states, Mr. Rollins suggested scanning federal and state data sources to strengthen ex parte verification, and Ms. Saunders suggested sharing information on how well different state medical frailty algorithms perform.

Several Commissioners raised concerns about medical frailty determinations:

- One Commissioner questioned the quality of claims data for frailty algorithms. Panelists said states are designing the process as an automated yes/no flag, so caseworkers are not making clinical judgments.
- A Commissioner who is a practicing pediatrician noted that a single diagnosis can mean very different levels of impairment and worried about the documentation burden on providers. Mr. Rollins said provider documentation is meant to be a last step after ex parte data.
- When asked whether any state's frailty approach has CMS's support, Mr. Rollins said CMS is not formally approving state frameworks but views Louisiana's approach as broadly aligned with its expectations.

Other Commissioners asked about presumptive eligibility, which will rely on self-attestation for CE, and about engagement with hospitals, federally qualified health centers, and community organizations, which panelists said is not yet a central focus for most states. Commissioners also asked about appeals capacity and provider rates for a potentially higher-acuity population. On rates, Mr. Rollins said heavy use of self-attestation may limit how useful 2027 data will be for future rate setting.

Lastly, one Commissioner asked what level of procedural disenrollment should cause concern. Ms. Saunders said results will vary widely based on each state's ex parte performance and pointed to Nebraska, with its broad self-attestation, extensive condition list, and small population, as an early case study. Neither panelist could yet share results from the early-implementing states.

STATE DIRECTED PAYMENTS AND HEALTH CARE-RELATED TAXES: SUMMARY OF PROPOSED RULES

This session began with MACPAC staff providing background on the limits to SDPs and provider taxes. Staff then summarized the SDP proposed rule to implement SDP payment limits and the targeted Medicaid payment limit in Fee-for-Service. Staff then summarized the proposed rule implementing changes to provider taxes, including changes to the indirect hold harmless (safe harbor) threshold, permissible classes, and eliminating the 75/75 test. Staff also highlighted the comment letters submitted to CMS about the proposed rules.

Commissioner Discussion

Commissioners had several questions about the new class of health insurers. One Commissioner asked why CMS added the class when other providers, particularly home and community-based services providers, have long sought one. Staff said CMS was aware of a few states with taxes on insurers that may be impermissible under current regulations and appeared to want to prevent states from shifting taxes to a new class outside the safe harbor limits. Another Commissioner asked whether the premium taxes that most states levy on insurers could be pulled into the class. Staff said the rule does not clearly separate the new class from the existing managed care organization class, which is why the Commission asked for clarification.

Several Commissioners focused on the scale and administrative burden of the SDP rule. One Commissioner noted that CMS's estimate of savings from the proposed rule is an order of magnitude larger than the estimate for the underlying legislation and said removing that much money from the system will affect access. The same Commissioner said it would be helpful to hear directly from CMS about how it plans to use the new reporting it will require from states and providers. Other Commissioners asked how states would calculate service-level Medicare equivalents. Staff explained that states could run Medicaid claims through the Medicare Severity Diagnosis-Related Group (MS-DRG) grouper or use CMS's online pricing tool, and that vendors, hospitals, and plans operating in both Medicare and Medicaid may help. They also said physician services should be easier because payment is largely based on CPT codes. In contrast, services without a Medicare equivalent, such as home and community-based services, would be limited to the state plan rate. One Commissioner suggested that CMS review summary-level data first and conduct service-level reviews only where issues are identified, rather than requiring states to reprice millions of managed care claims.

Commissioners also raised the following concerns about access and innovation:

- Rural hospitals may reduce services such as maternity care or close before the effects of the new limits are fully understood, and those services are hard to restore.
- Service-level limits could constrain value-based payment arrangements, including efforts to improve access to maternity and dental services.

- Rural and tribal communities may be hit at the same time by lower payments and coverage losses from CE requirements.
- If payment increases are less available, MACPAC could examine other barriers to provider participation, such as payment delays and documentation requirements, particularly in behavioral health.

One Commissioner noted that MACPAC did not comment on CMS's choice of phase-down method, which staff described as faster but simpler to administer. The same Commissioner highlighted that expansion states face lower safe harbor thresholds than non-expansion states, which could offer a way to compare access effects between the two groups over time. Another Commissioner said they would like to hear directly from expansion states about the options they are considering to replace provider tax revenue for the non-federal share.

INPATIENT HOSPITAL PAYMENT INDEX: COMPARISON ACROSS STATES

The session began with MACPAC staff presenting an update to the Commission's Inpatient Hospital Payment Index. The update will be published in 2027 and is being developed using 2022 data. Staff provided Commissioners an overview of the methodology, the index findings, and the limitations of the analysis. Staff then discussed next steps and future analysis plans, including comparing Medicaid inpatient hospital payment to Medicare payment rates, grouping Medicaid claims to allow service-level comparison, and beginning a similar analysis for outpatient services.

Commissioner Discussion

Commissioners broadly praised the work and the transparency around its limitations. One Commissioner said the net payment measure is especially valuable because it reflects the money actually available to support hospital operations, but suggested acknowledging that some states use provider tax revenue to fund Medicaid expansion or general revenue rather than hospital payments, which means hospitals in those states bear a larger net burden. Another Commissioner asked how the 2017 index has been used. Staff said it has been widely cited, including by the American Hospital Association, because no comparable public analysis existed.

Commissioners also raised technical questions. Staff confirmed that the national average is weighted, that inpatient psychiatric hospitals were excluded, and that no specific adjustment was made for third-party liability. Two Commissioners suggested applying the wage and case mix adjustments to gross and net payments as well as base payments, since a dollar goes further in some states than others. They asked that the two adjustment factors be reported separately. Staff said they applied the adjustments only to base payments because supplemental payments are typically set as lump sums that do not vary with acuity but acknowledged the case for broader application.

Several Commissioners suggested ways to break out or contextualize the findings, including by:

- Comparing results for expansion and non-expansion states, and considering the role of uncompensated care pools in states such as Texas and Florida
- Vetting the variation in net payments with researchers and states before publication, since hospitals will be very interested in where they fall
- Accounting for the fact that plans often negotiate inpatient and outpatient rates together
- Separating results for high-Medicaid critical access hospitals, freestanding children's hospitals, and urban, rural, and frontier hospitals, as well as public, private, and teaching hospitals
- Including a table of average dollar payments per stay by state, since index values can mask large differences in actual amounts

One Commissioner cautioned that 2022 data predate substantial growth in SDPs and would likely look very different today. The same Commissioner recalled that when Ohio previously reset its hospital rates, urban hospitals were at roughly 80% cost coverage and rural hospitals at roughly 35%, and raising rural hospitals to parity cost relatively little because of their small share of spending. On the outpatient analysis, staff said they will identify services using CMS's federally assigned service categories and may need to benchmark against cost reports rather than Medicare because of gaps in outpatient data.

At the conclusion of the session, MACPAC opened the floor for public comment. Rob Nelb, Director of Policy at America's Essential Hospitals, shared the Commission's concerns about the service-level SDP limit and noted that his organization led a coalition letter with more than 24 provider, plan, and consumer groups on its effect on value-based payment. He said the Congressional Budget Office projected the SDP provisions would reduce spending by about \$149 billion over 10 years. He said this contrasts with CMS projections of \$510 billion in reductions under the proposed rule, or 3.4 times the congressional estimate. He urged the Commission to examine the effects on essential hospitals. He pointed to his organization's proposed essential health system designation, which builds on MACPAC's prior work on deemed disproportionate share hospitals.

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