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INSIGHTS

Select Sessions from MACPAC October Meeting: Hospital Cost Drivers and Work Requirements Implementation

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On October 29, 2026, the Medicaid and CHIP Payment and Access Commission (MACPAC) opened its October meeting with a session on what drives hospital costs and how those cost factors are reflected in state Medicaid hospital payment methods and rates. The Commission then turned to an update on its monitoring of state implementation of Medicaid work requirements under the One Big Beautiful Bill Act (OBBBA). The meeting included a panel featuring the Medicaid directors of Indiana and Colorado and the head of Nebraska's health center association.

HOSPITAL COST DRIVERS

The session began with MACPAC staff outlining their planned project related to hospital cost drivers, which will also include an update of MACPAC's Inpatient and Outpatient Hospital Payment Compendia and a round of stakeholder interviews. Staff reviewed how states pay for inpatient and outpatient hospital services, including base payment methods and supplemental payments, which account for nearly half of Medicaid payments to hospitals. They also distinguished hospital costs, meaning the resources hospitals use to deliver care, from spending, meaning what payers pay for that care. They also shared findings from a literature review that identified labor, supplies, facilities, and overhead as the primary cost drivers, along with the volume, intensity, and location of services. Staff noted that evidence on cell and gene therapies, artificial intelligence, market concentration, ownership (including private equity acquisition), and cost containment policies such as price transparency was less conclusive.

Staff will return in January with findings from the payment policy compendium and a descriptive chapter for the 2027 Report to Congress. They asked Commissioners which cost drivers, payment policies, services, and hospital types to prioritize in stakeholder interviews.

Commissioner Discussion

Several Commissioners questioned how managed care fits into an analysis that centers on fee-for-service payment. One Commissioner asked what share of Medicaid hospital payments flow through fee-for-service. Staff pointed to a 2022 MACPAC issue brief that put the figure at roughly 48%, which they will confirm, and said the share has likely shifted as managed care has expanded. The Commissioner worried that leaving managed care out would miss a large portion of payments and limit the reach of any future recommendations. Another Commissioner built on that point, suggesting that in states where nearly all

enrollees are in managed care, fee-for-service rates may not track hospital costs closely, and asked staff to explore the issue in interviews. The same Commissioner asked how state-directed payments (SDPs) would factor into a fee-for-service analysis. Staff said they would follow up but expected to consider SDPs to the extent they affect overall hospital operations.

One Commissioner praised staff for separating costs from spending and asked them to keep that distinction sharp. The Commissioner requested a sense of scale for each driver, such as how much cost growth comes from labor versus supplies. The Commissioner also asked staff to distinguish spending growth from rising prices, possibly tied to consolidation, from spending growth driven by utilization.

Another Commissioner, a former Washington, DC Medicaid director, said drivers of hospital costs require significant nuance and may be better analyzed at the state level than nationally. The Commissioner recommended the National Academy for State Health Policy's hospital cost tool, which includes data through 2024, as something that could be helpful. The Commissioner also raised several points:

- Administrative costs include management fees that hospitals send to their parent health systems and transfers to affiliated foundations, which may not be captured, so staff should be clear whether they are examining hospital or system costs.
- Understanding why hospitals close is essential before making recommendations. In some non-expansion states, Medicaid is not a large payer and uncompensated care is the bigger problem.
- SDPs have become a major share of Medicaid hospital reimbursement and cannot be left out.
- States have several levers to keep a hospital open, including direct general fund support outside of Medicaid. When DC General Hospital closed despite the city's efforts, DC created a program covering residents below 200% of the federal poverty level, illustrating the trade-off between preserving a facility and expanding coverage.

Commissioners also raised questions about how hospitals choose their service mix and where care is delivered:

- One Commissioner asked staff to examine how hospital service line decisions relate to community need, noting a shift toward profitable, high-acuity services such as specialized cardiac units and away from maternity and mental health care.
- Another Commissioner noted declining use of some outpatient hospital services as competitors without facility fees emerge, and price transparency grows. This Commissioner then asked what share of costs and spending facility fees represent and for which services.
- A third Commissioner asked staff to look at off-campus outpatient clinics and freestanding emergency rooms that bill as hospitals without providing hospital services, including their costs and the revenue they generate.

- Another Commissioner asked staff to study how health professional shortage areas and weak primary care infrastructure push patients toward higher-acuity hospital care. The Commissioner also urged attention to small rural hospitals that are not critical access hospitals, as margins are just under 1%.

One Commissioner asked staff to consider how state regulations affect rural hospitals. As an example, this Commissioner pointed to staffing rules in California requiring a labor and delivery unit to keep specialists such as an anesthesiologist available around the clock. The Commissioner noted that these rules were even in effect at a rural hospital that handles only a few deliveries a month, until they were later loosened for rural hospitals in hopes of keeping their units open. The Commissioner also asked whether last-resort programs such as California's distressed hospital loan program, run by the Department of Health Care Access and Information (HCAI), actually keep hospitals open or only delay closure. The Commissioner urged MACPAC to track what happens to rural hospitals as compliance dates under the new rules limiting SDPs arrive.

The Chair focused on market concentration and ownership. She asked how to interpret findings that private equity acquisitions lower operating costs while also reducing staffing and Medicaid discharges, and what evidence would separate genuine efficiency from reduced services or access for Medicaid patients. She also asked whether those effects differ for rural and safety net hospitals. The Vice Chair closed the discussion recommending that staff examine emergency department and inpatient boarding of both adults and children who remain in the hospital because outpatient services are unavailable, which adds costs for hospitals and payers. On AI, he suggested the lack of measurable savings from scribe tools may reflect physicians completing documentation during off hours, so the benefit shows up in quality of life rather than in hospital costs. He urged close attention to rural, safety-net, and children's hospitals, noting that safety-net and children's hospitals often have Medicaid shares of 50% to 75% or more and that Medicare benchmarks do not work well for them. He added that his state has seen private equity-owned hospitals fail after owners declined to invest in infrastructure and staffing.

MEDICAID WORK REQUIREMENTS: MONITORING STATE IMPLEMENTATION

MACPAC staff opened the session by announcing that the Commission will now use the term work requirements instead of community engagement, consistent with CMS's messaging recommendations and federal and state outreach campaigns. Staff then presented findings from MACPAC's monitoring of state readiness, medical frailty, beneficiary outreach, and federal and state reporting. Stakeholders said many states will keep updating their IT systems well into 2027 while implementing several other eligibility changes at once. Most states will rely on self-attestation in 2027 for activities and exclusions they cannot verify ex parte (without clarification from the individual) including medical frailty. Staff noted that CMS has not yet released a template for good faith exemption requests, and that five governors wrote to HHS on October 1, 2026, asking for a delay to the January 1, 2027, start date.

Staff also shared early data from Nebraska, which implemented work requirements on May 1, 2026. Call volume and average wait times rose between January and August, and most denied applications and renewals resulted from non-response rather than noncompliance. Staff closed with updates on two pending lawsuits challenging the interim final rule (IFR), including its medical frailty provisions, sharing that a hearing for a summary motion took place for one and no movement occurred for the other. Staff noted they will return in December with further monitoring updates.

Commissioner Discussion

Commissioners focused heavily on the Nebraska data. One Commissioner confirmed that non-response accounted for 83.7% of denied applications and 91.9% of denied renewals and asked how that compares with non-response in regular renewals. Staff said Nebraska's data covered only the expansion population, so no comparison is possible yet. When asked how to distinguish people who do not meet the requirements from those who simply could not navigate the process, staff said stakeholders attributed much of the non-response to confusion, with many beneficiaries unaware they were subject to the requirements or assuming they would not qualify for Medicaid with the work requirements. Two Commissioners raised concerns about call center performance. One called an average wait of 24 minutes appalling and said Medicaid enrollees deserve better service. Another said the bigger concern was the gap between the state's averages and the three-hour waits beneficiaries are reporting. She suggested MACPAC conduct secret shopper calls across states after the January rollout, push for clearer descriptions of how states calculate wait times, and encourage states to post live dashboards showing the best times to call.

Commissioners raised several other questions:

- One Commissioner asked how states will handle exceptions for counties with high unemployment, given that Bureau of Labor Statistics data are backward-looking. Staff said some states have begun requesting short-term hardship exceptions and will continue to monitor.
- Another Commissioner asked whether states are adjusting provider rates, particularly for rural hospitals, or managed care capitation rates to reflect changes in the enrolled population. Staff said they have not seen this publicly or in interviews but will look into it.
- The same Commissioner asked whether states are adopting newer, more consumer-friendly eligibility tools. Staff said CMS has focused mainly on adding data sources to the Federal Data Services Hub and that it is unclear how much CMS is helping states work with these vendors.
- One Commissioner cautioned against drawing firm conclusions from Nebraska's small sample and asked how many states are hiring eligibility staff or assisters. Staff pointed to a KFF survey from March 2026, conducted before the IFR, and said that states adding capacity still face recruitment challenges and steep training demands.

Panel on Medicaid Work Requirements: State Implementation

The meeting included a panel featuring Audrey Frenzel, Medicaid Director and Director of the Office of Medicaid Policy and Planning at the Indiana Family and Social Services Administration; Adela Flores-Brennan, Medicaid Director for the Colorado Department of Health Care Policy and Financing; and Amy Behnke, Chief Executive Officer of the Health Center Association of Nebraska, which represents the state's seven federally qualified health centers (FQHCs).

Ms. Frenzel explained that Indiana is implementing a state law that is more stringent than the OBBBA. Indiana will run quarterly compliance checks requiring enrollees to show compliance in each month of the quarter, conduct redeterminations every six months, and will not accept self-attestation. The state announced its medical frailty framework, which uses MARA, a structured claims-based tool developed by Milliman that replaces a tool the state has used since 2024. The tool looks at diagnosis codes, place of service, durable medical equipment, and the frequency of medication and treatment. Indiana has published roughly 4,200 Tier 1 diagnosis codes and will run the tool on all current members and notify them of the result before January 1, 2027. When the tool cannot confirm frailty, providers may submit clinical documentation under penalty of perjury.

Ms. Flores-Brennan said Colorado began systems integration and user acceptance testing and recently held a webinar for about 4,000 stakeholders. She named time, budget, and competing priorities as the state's biggest challenges, along with preparing frontline workers while the system is still being tested. Ms. Behnke said Nebraska's health centers engaged early with the state Department of Health and Human Services and still meet monthly. She credited the state for choosing the least restrictive options, such as requiring proof of compliance for only one month of the look-back period, and for being transparent that processes will evolve. She said implementing before the IFR created uncertainty, the decision not to hire more caseworkers has lengthened call wait times and application processing, and outreach groups have received only one round of state data as of the panel's convening, released in mid-September.

Commissioners asked several questions about medical frailty determinations. One Commissioner asked how Indiana's claims-based approach accounts for conditions such as major depressive disorder or PTSD, where barriers to care and the symptoms themselves may mean little claims history. Ms. Frenzel said Indiana runs Tier 1 (diagnosis codes) and Tier 2 (utilization, such as recent inpatient or outpatient treatment) at the same time, so a diagnosis alone does not establish frailty. She said an early run using the five federal domains without further rules would have deemed nearly the entire expansion population frail. She then noted that this example highlights the need to balance sensitivity and specificity. She expects to rely more on provider documentation for new enrollees with no claims history. Ms. Flores-Brennan said Colorado will accept self-attestation as a safety net and has adopted

the Harvard methodology. She described people in her own life who had to quit their jobs because of their health but could not get a diagnosis for six months, and said Colorado plans an RFP for a vendor that could pull electronic health record data, since verification after 2028 remains an open question. When asked how many enrollees could be found frail ex parte, Ms. Flores-Brennan said the Harvard tool identified about 160,000 (plus or minus 5,000) of Colorado's 377,000 modified adjusted gross income (MAGI) adults as medically frail, roughly 40%, out of 1.2 million total Medicaid enrollees. Ms. Behnke said Nebraska uses a roughly 300-page code document and a 12-month claims look-back for existing enrollees, with self-attestation for everyone else until 2028.

On new eligibility technology, both state Medicaid directors said limited time and system complexity have kept them from adopting new tools. Ms. Flores-Brennan said Colorado receives multiple vendor pitches a day but faces state procurement guidelines and plans to reprocure its eligibility system in the next few years. Colorado will not have short-term hardship exceptions in place at go-live because it ran out of time and capacity. Ms. Flores-Brennan added that Colorado had planned to use the federal tool CMS had been developing but backed away when it did not come to fruition. Ms. Frenzel said Indiana modified its integrated eligibility system through existing contracts but could not use the federal eligibility tool because the system is highly customized.

Another Commissioner asked about audit risk. Ms. Flores-Brennan said Colorado is very worried, noting the state is in the second cycle of Payment Error Rate Measurement (PERM) audits, which are set to begin in June or July 2027. Colorado is documenting its unanswered questions and plans to request PERM relief, as CMS granted during ACA implementation. She also noted that CMS released a multi-page mitigation strategy document the previous week, with a fillable form for states to identify the strategies they will use, such as broad social media outreach when direct notices are not possible.

One Commissioner noted that more than 80% of Nebraska's denials stemmed from non-response, describing the situation as "unwinding 2.0" with greater complexity, and asked about outreach best practices. Panelists described the following approaches:

- Ms. Behnke (NE): Health centers simplify state materials (with state review and approval), coordinate with community partners so every organization uses the same language, and rely on social media, short videos, community meetings, one-on-one help, and a website that helps people find an assister.
- Ms. Flores-Brennan (CO): The state partnered with the Center for Advancing Consumer Participation, funded by a local foundation, to build a co-brandable toolkit of social media posts, newsletter content, flyers, lobby videos, and translated materials. Colorado also offers screener tools for work requirements and immigrant eligibility and will relaunch an ambassador program that gives mini-grants to community organizations to serve as trusted local messengers.

- Ms. Frenzel (IN): The state uses similar toolkits and screeners and tracks engagement, such as how many town hall viewers then check their status in the benefits portal and where viewers stop watching informational videos. Ms. Frenzel stressed that meeting notice requirements is not the same as changing behavior.

Another Commissioner asked Ms. Frenzel about Indiana's fiscal analysis for its legislature. She said the state projects about $50 million in first-year costs to implement the OBBBA and Indiana's state law, driven by 400 new eligibility staff, secure workspace, and mail costs tied to quarterly compliance checks. She said earlier Indiana data showed that adding eligibility staff improved timeliness and lowered the state's PERM error rate. Indiana will track results against its projections and make them public, including through the State Budget Committee and the coming legislative session.
In response to staff questions, panelists described the following workforce and operational challenges:

- Ms. Behnke said Nebraska's roughly 70,000 expansion enrollees cannot easily learn they are in the expansion group, and a portal update to show this is several months away. She called enrollment assisters the most valuable tool in implementation, since they often come from the same communities as patients, receive enrollees' mail through authorized representative forms, and flag systemic problems.
- Ms. Behnke said two-hour call waits are common and that a system glitch disconnects callers after two hours, forcing them to call back, which accounts for the three- to four-hour waits reported. Application processing times have also grown, and one rural local office has begun referring walk-ins to the community health center.
- Ms. Flores-Brennan said Colorado's eligibility workforce is administered by its 64 counties, which are developing staffing plans. The state holds Q&A sessions with county workers, maintains a resource web page, and will roll out formal training in November and early December, close to go-live.
- Ms. Frenzel said Indiana's training is ongoing and will likely require additional FAQs as new issues emerge.

On partnerships with managed care organizations (MCOs) and providers, Ms. Frenzel said Indiana distributed a provider toolkit and that MCO claims history will be important for frailty determinations as the state sees churn from its delayed unwinding. Indiana is also exploring Kentucky's practice of listing an enrollee's next redetermination date on provider eligibility responses. Ms. Flores-Brennan said Colorado meets regularly with MCOs and is scheduling roundtables with primary care providers. Ms. Behnke said two of Nebraska's three Medicaid MCOs are sharing data on attributed patients with health centers, and health centers are exploring access to denial data so they can follow up on procedural denials.

When asked what they would request with a magic wand, Ms. Flores-Brennan said more time and that even as a longtime Medicaid official she struggled to follow her own state's webinar. Ms. Behnke asked for simplification, warning that young, relatively healthy people may walk away from coverage altogether. Ms. Frenzel said she supports work requirements for able-bodied adults philosophically, but wished policymakers understood "the math of Medicaid," as disenrolling someone does not save Indiana general fund dollars when that person later shows up uninsured at a hospital, particularly given pressures on hospital assessment fees, SDPs, and provider taxes.

Commissioners closed the session with several broader concerns:

- One Commissioner asked how MACPAC could track the effect of look-back periods on people who could not work because of a newly diagnosed illness, such as cancer, so the evidence is not merely anecdotal. Staff said they would consider options.
- Another Commissioner asked whether anyone is tracking how many people gain jobs, since that would be the key metric if employment is the goal. She warned that claims-based frailty tools create a perverse incentive for people with serious depression or PTSD to visit the emergency department simply to generate a record of acuity, particularly in states that do not allow self-attestation.
- A third Commissioner worried that physician documentation of frailty could introduce bias against people with invisible disabilities and asked what criteria and training, such as trauma-informed care, physicians will receive.
- One Commissioner called for an evaluation of the cumulative impact of work requirements, SDP reductions, financing changes, and payment rate changes, to see the total effects of all policy changes.

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