Report to Congress on Medicaid and CHIP

JUNE 2026

MACPAC
Medicaid and CHIP Payment and Access Commission

MACPAC

About MACPAC

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, 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 MACPAC's 17 commissioners, who come from diverse regions across the United States and bring broad expertise and a wide range of perspectives on Medicaid and CHIP.

MACPAC serves as an independent source of information on Medicaid and CHIP, publishing issue briefs and data reports throughout the year to support policy analysis and program accountability. The Commission's authorizing statute, Section 1900 of the Social Security Act, 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.

MACPAC's authorizing statute also requires the Commission to submit reports to Congress by March 15 and June 15 of each year. In carrying out its work, the Commission holds public meetings and regularly consults with state officials, congressional and executive branch staff, beneficiaries, health care providers, researchers, and policy experts.

Report to Congress on Medicaid and CHIP

JUNE 2026

MACPAC
Medicaid and CHIP Payment and Access Commission

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June 15, 2026

The Honorable JD Vance
President of the Senate
The Capitol
Washington, DC 20510

The Honorable Mike Johnson
Speaker of the House
The Capitol
Washington, DC 20515

Dear Mr. Vice President and Mr. Speaker:

On behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC), I am pleased to submit the June 2026 *Report to Congress on Medicaid and CHIP*. This report includes recommendations related to community engagement (CE) requirements in Medicaid, automation in prior authorization (PA), Medicaid managed care accountability, appropriate access to residential treatment services for Medicaid-enrolled youth, transitions to adult Medicaid coverage for children and youth with special health care needs (CYSHCN), and the Program of All-Inclusive Care for the Elderly (PACE) as well as a chapter on provider enrollment in Medicaid.

Chapter 1 contains a recommendation to create a transparent plan for monitoring and evaluating CE requirements in Medicaid. Under the 2025 Budget Reconciliation Act (P.L. 119-21), states will be required to make Medicaid eligibility for certain applicants and existing beneficiaries contingent on their participation in qualifying CE activities. The chapter outlines the need for timely guidance and technical assistance to states; steps to reduce coverage losses; the need for efficiency when procuring, updating, and operating state information technology systems; and the use of timely monitoring and evaluation data to inform policy and operations. MACPAC's research highlights the need to monitor eligibility and enrollment changes following implementation of the CE requirement.

Chapter 2 focuses on automation in Medicaid PA. MACPAC has looked at how payers and providers are increasingly incorporating technology, including artificial intelligence, to automate parts of the Medicaid PA process. Automated PA processes present potential risks to beneficiaries, states, providers, and health plans, and there is limited transparency into how these tools make decisions. In addition, there is little federal guidance on these tools, and state guidance varies. MACPAC makes recommendations to address the risks posed by automation tools, strengthen oversight, and increase disclosure and transparency of managed care plans' use of automation in PA.

Chapter 3 offers recommendations to improve managed care plan accountability. Managed care is the predominant Medicaid delivery system in most states. Although the Centers for Medicare & Medicaid Services and states have made efforts to strengthen oversight of managed care programs, little is known about the accountability tools state Medicaid agencies use to ensure managed care plans comply with contract requirements and meet performance expectations. The recommendations seek to improve the usability of managed care performance data and provide states with additional guidance and tools to more effectively assess and oversee plan performance.

Chapter 4 looks at appropriate access to residential treatment services for youth who are enrolled in Medicaid. Federal law requires that services (e.g., behavioral health) be provided to youth with disabilities. Some youth with intense treatment needs or those who pose a safety risk to themselves or their families and cannot be served in the community require access to residential treatment. For children whose needs cannot be met in the community, it is important that residential treatment options be available when they are needed. However, difficulty finding real-time information on facility and bed availability and specialized care can hinder access to residential services. In addition, there is no single federal data source on the use of residential treatment, including in out-of-state facilities. The Commission makes recommendations aimed at improving appropriate access to residential behavioral health treatment for Medicaid-enrolled children and youth.

Chapter 5 contains recommendations to ease the transition to adult Medicaid coverage for CYSHCN. Medicaid-covered CYSHCN often navigate multiple, sometimes overlapping, transitions as they reach adulthood. In addition to transitioning from child to adult Medicaid eligibility, they may simultaneously undergo the Supplemental Security Income (SSI) age-18 redetermination and transition from child-only to adult 1915(c) home- and community-based waivers. Key challenges with the transition to adult Medicaid coverage include insufficient time to prepare and respond to Medicaid redetermination notices, lack of clarity about changes to SSI and how it affects Medicaid eligibility, and inconsistent support with the Medicaid redetermination and other simultaneous transitions.

Chapter 6 focuses on PACE, which provides integrated care to adults age 55 and older who meet nursing facility level-of-care criteria and can live safely in the community. Findings from MACPAC's June 2025 report to Congress identified questions related to transparency in state and federal oversight of PACE compliance and quality. Our research found overlap and lack of coordination in federal and state audit activities and limited availability of information on PACE program quality and performance. The Commission makes recommendations aimed at improving coordination on audits, making existing PACE performance information publicly available, and developing a standard national quality measure set for PACE organizations.

The final chapter of the June report looks at Medicaid provider enrollment and managed care credentialing, which is designed to ensure that Medicaid enrollees receive care from qualified providers. In addition, these processes are intended to prevent the enrollment of providers who have criminal records related to federal health programs or who have engaged in fraud, waste, or abuse. The chapter provides an overview of federal requirements for provider enrollment and credentialing in Medicaid, the approaches taken by three states, and challenges for states and providers. It includes insights into barriers faced by certain provider types or challenges related to specific parts of the enrollment and credentialing processes as well as their effects on provider participation, state administrative burden, and program integrity.

MACPAC is committed to providing in-depth, non-partisan analyses of Medicaid and State Children's Health Insurance Program policy, and we hope this report will prove useful to Congress as it considers future policy development affecting these programs. This document fulfills our statutory mandate to report each year by June 15.

Sincerely,

Verlon Johnson, MPA

Chair

Medicaid and CHIP Payment
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Executive Summary: June 2026 *Report to Congress on Medicaid and CHIP*

MACPAC's June 2026 *Report to Congress on Medicaid and CHIP* contains seven chapters of interest to Congress: (1) community engagement (CE) requirements in Medicaid, (2) automation in prior authorization (PA), (3) Medicaid managed care accountability, (4) appropriate access to residential treatment services for Medicaid-enrolled youth, (5) transitions to adult Medicaid coverage for children and youth with special health care needs (CYSHCN), (6) the Program of All-Inclusive Care for the Elderly (PACE), and (7) provider enrollment in Medicaid.

CHAPTER 1: Implementing Community Engagement Requirements in Medicaid

Chapter 1 includes a recommendation to create a transparent plan for monitoring and evaluating CE requirements in Medicaid. Under P.L. 119-21, an Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 (2025 Budget Reconciliation Act), states will be required to make Medicaid eligibility for certain applicants and existing beneficiaries contingent on their participation in qualifying CE activities. The chapter outlines the need for timely guidance and technical assistance to states; steps to reduce coverage losses; the need for efficiency when procuring, updating, and operating state information technology systems; and the use of timely monitoring and evaluation data to inform policy and operations. MACPAC's research highlights the need to monitor eligibility and enrollment changes following implementation of the CE requirement.

In this chapter, we make the following recommendation:

1.1 The Secretary of the U.S. 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 (CE) requirements in Medicaid. The monitoring plan should provide insight into how such policies affect eligibility and enrollment. CMS should identify new metrics for state reporting and build upon existing data collection to minimize administrative burden. The evaluation plan should outline, at a minimum, CMS's approach to evaluating the effect of CE requirements on employment, health, and state and federal administrative and program spending. CMS should ensure timely publication of monitoring and evaluation results to inform policy and operational decision making.

CHAPTER 2: Automation in Prior Authorization

PA is the multistep process by which health care payers require medical providers to request and receive approval before providing certain items, services, or medications. PA is widely used in Medicaid managed care and fee for service. The Commission conducted a study to understand the extent to which states, managed care plans, and providers use automation (i.e., artificial intelligence (AI) and algorithms) in the Medicaid PA process and to identify potential policy levers to oversee its use. Automated systems that use algorithms or AI to conduct portions of the PA process have the potential to reduce burdens associated with PA and promote appropriate, cost-effective care. However, automated PA processes present potential risks to beneficiaries, states, providers, and health plans, and there is limited transparency into how these tools make decisions. In addition, there is little federal guidance on these tools, and state guidance varies.

In this chapter, we make the following recommendations:

2.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance to state Medicaid agencies and Medicaid managed care plans clarifying that, for determinations of medical necessity, the language at 42 CFR 438.210(b)(3) requires an individual with appropriate expertise to review and authorize all decisions to deny service authorizations or to authorize a service in an amount, duration, or scope that is less than requested, including those proposed by automated systems. This

guidance should clarify further that (1) adverse determinations may not be made by automation tools alone; (2) adverse determinations must be made based on individualized determinations of medical necessity; and (3) all existing regulatory requirements related to adverse determinations apply whether or not automation is used in the process of issuing an authorization decision.

2.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend the regulations at 42 CFR 440.230 to provide that, for determinations of medical necessity in fee-for-service Medicaid programs, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

2.3 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance to state Medicaid agencies and Medicaid managed care plans specifying ways in which existing regulatory oversight processes (42 CFR 438.66), including the external quality review process (42 CFR 438.350) and mandated plan reporting required for Managed Care Program Annual Reports (42 CFR 438.66(e)(1)), can be used to create effective oversight of managed care plans' use of automation in prior authorization.

2.4 State Medicaid agencies should amend their Medicaid managed care plan contracts, on a timeline that is practicable, to require disclosure or other reporting of the use of automation in plans' coverage and authorization processes described at 42 CFR 438.210. Disclosure should facilitate state visibility into the applications of automation tools and other meaningful elements of automation, such as plans' protocols for testing, evaluation, and oversight. To the extent possible, states should modify existing reporting requirements or existing oversight processes to minimize additional administrative burden.

CHAPTER 3: State and Federal Tools for Ensuring Accountability of Managed Care Plans

Chapter 3 offers recommendations to improve managed care plan accountability. Managed care is now the predominant Medicaid delivery system in most states. Although the Centers for Medicare & Medicaid Services and states have made efforts to strengthen oversight of managed care programs, little is known about the accountability tools state Medicaid agencies use to ensure managed care plans comply with contract requirements and meet performance expectations. The recommendations seek to improve the usability of managed care performance data and provide states with additional guidance and tools to more effectively assess and oversee plan performance.

In this chapter, we make the following recommendations:

3.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to provide guidance on how to consistently report the types of accountability actions, such as liquidated damages, informal interventions, and other accountability actions taken in response to plan noncompliance, in the sanction section of the Managed Care Program Annual Report pursuant to 42 CFR 438.66(e)(2)(viii).

3.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & 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.

CHAPTER 4: Access to Appropriate Residential Treatment Services for Youth in Medicaid

Chapter 4 looks at appropriate access to residential treatment services for youth who are enrolled in Medicaid. Federal law requires services (e.g., behavioral health) to be provided to youth with disabilities. Some youth with intense treatment needs or who pose a safety risk to themselves or their families and cannot be served in the community require access to residential treatment. For children whose needs cannot be met in the community, it is important that residential treatment options be available when they are needed. However, difficulty finding real-time information on facility and bed availability and specialized care can hinder access to residential services. In addition, there is no single federal data source on the use of residential treatment, including in out-of-state facilities. MACPAC found that numerous factors affect access to residential treatment for Medicaid-covered children. Those factors include a lack of home- and- community-based behavioral health services, existing federal policies that pose barriers to appropriate residential treatment, state challenges finding information on facility and bed availability, a lack of uniformity in assessing children's need for residential behavioral health care, no single national source of data on children who access residential treatment services, and workforce issues that make it challenging for states to operate facilities at their full licensed residential bed capacity.

MACPAC will continue to look at issues affecting access to home- and community-based behavioral health services for children as well as additional topics related to the safety and quality of appropriate residential treatment services.

In this chapter, we make the following recommendations:

4.1 To ensure that states, families, and providers have complete, accurate, and up-to-date information about residential treatment facilities and bed availability, Congress should require that the Secretary of the U.S. Department of Health and Human Services (HHS) develop, maintain, and make publicly available a federally administered, up-to-date, real-time registry of youth residential treatment facilities serving Medicaid beneficiaries. The Secretary should work with HHS agencies, including the Centers for Medicare & Medicaid Services and the Substance Abuse and Mental Health Services Administration, state Medicaid agencies, state behavioral health agencies, and other stakeholders to develop and maintain this registry. The registry should include information on the behavioral health conditions facilities treat, ages served, real-time updates to bed availability for in- and out-of-state Medicaid beneficiaries, and accessibility of facilities and services for individuals with disabilities. The Secretary should leverage information already being collected by federal agencies and states, while also integrating other information needed to determine whether the facility can meet beneficiary need.

4.2 To ensure that reliable and consistently collected data are publicly available, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to regularly report on the use of residential treatment services by children and youth in Medicaid, including services provided by psychiatric residential treatment facilities (PRTF), non-PRTFs, and out-of-state residential treatment providers. This report should contain data on the characteristics of youth using the services including demographics, disability and co-occurring conditions, and urbanicity and rurality; types of services used; and average length of stay. The report should include data on the use of emergency departments for behavioral health needs, such as emergency department boarding by youth with Medicaid. If data are unavailable to report on key measures, CMS should develop a plan for collecting and publicly reporting on the data elements. CMS should engage states, providers, and other stakeholders in developing the data collection and reporting efforts.

4.3 To ensure that youth discharged from out-of-state residential treatment facilities return to their home states and communities and receive needed services, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend 42 CFR 441.155 to establish minimum

requirements for discharge planning processes that mandate that the process involves all relevant actors including providers, plans, and families and caretakers. The requirements should mandate that the process involves identifying an appropriate community provider or alternative residential placement that has the capability and capacity to accept the beneficiary prior to discharge. CMS should also clarify what entities are responsible for initiating and overseeing the discharge planning process for an out-of-state beneficiary, and establish minimum requirements for coordinating and sharing information between the out-of-state provider and the post-discharge providers.

CHAPTER 5: Children and Youth with Special Health Care Needs Transitions to Adult Coverage

Chapter 5 contains recommendations to ease the transition to adult Medicaid coverage for CYSHCN. Medicaid-covered CYSHCN often navigate multiple, sometimes overlapping, transitions as they reach adulthood. In addition to transitioning from child to adult Medicaid eligibility, they may simultaneously undergo the Supplemental Security Income (SSI) age-18 redetermination and transition from child-only to adult 1915(c) home- and community-based waivers. Key challenges with the transition to adult Medicaid coverage include insufficient time to prepare and respond to Medicaid redetermination notices, lack of clarity about changes to SSI and how it affects Medicaid eligibility, and inconsistent support with the Medicaid redetermination and other simultaneous transitions.

In this chapter, we make the following recommendations:

5.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend 42 CFR 435.919(b)(6) to require states to send a notice a minimum of 60 days in advance of children and youth with special health care needs (CYSHCN) aging out of child Medicaid eligibility to inform them that the renewal process has been initiated. CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

5.2 State Medicaid agencies should provide children and youth with special health care needs (CYSHCN) who are aging out of child Medicaid eligibility with a minimum of 30 days to respond to requests for information to complete Medicaid redeterminations in accordance with 42 CFR 435.919(c)(1). CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

5.3 To ensure the accuracy of information provided by the Social Security Administration (SSA) to Medicaid beneficiaries enrolled in Supplemental Security Income (SSI)-related eligibility pathways who are being notified that they are losing eligibility for SSI, the Secretary of the U.S. Department of Health and Human Services, through the Centers for Medicare & Medicaid Services, should coordinate with SSA to review and update model notice language pertaining to Medicaid in SSA's Program Operations Manual System manual paragraphs. The model language should clearly indicate that the individual may retain their Medicaid coverage while the state Medicaid agency takes steps to redetermine the individual on a new basis of eligibility. Additionally, the model language should describe, in general terms, the steps the individual needs to follow to complete the Medicaid redetermination that are specific to 1634, SSI criteria, and 209(b) states.

5.4 State Medicaid agencies should implement optional Medicaid eligibility for children and youth with special health care needs (CYSHCN) up to age 21 who are not otherwise eligible for and enrolled in mandatory coverage or optional full Medicaid coverage under the state plan (42 CFR 435.222 and 42 CFR 435.223). CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under The Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

5.5 To ensure children and youth with special health care needs (CYSHCN) receive a full 12-month continuous eligibility period in their final year of child Medicaid eligibility, Congress should amend § 1902(e)(12) of the Social Security Act to require states to provide CYSHCN with a 12-month continuous eligibility period that lasts a full 12 months from the date of the eligibility determination, even if during the continuous eligibility period, an individual reaches the upper age limit for the eligibility pathway by which they are eligible for Medicaid. This 12-month continuous eligibility period should apply to all CYSHCN who receive coverage from a mandatory or optional child eligibility pathway, including optional pathways covering youth above age 18. CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

5.6 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance to states on existing authorities for supporting children and youth with special health care needs (CYSHCN) with Medicaid redeterminations and transitioning to adult Medicaid coverage. The guidance should address authorities to cover case management, transition planning for child-only Section 1915(c) home- and community-based services waivers, and the state optional pathway to cover children up to age 21. CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

CHAPTER 6: Exploring the Role of the State Medicaid Agency in the Program of All-Inclusive Care for the Elderly

Chapter 6 focuses on PACE, which provides integrated care to adults age 55 and older who meet nursing facility level-of-care criteria and can live safely in the community. Findings from MACPAC's June 2025 report to Congress identified questions related to transparency in state and federal oversight of PACE compliance and quality. MACPAC's research found overlap and lack of coordination in federal and state audit activities and limited availability of information on PACE program quality and performance. The Commission makes three recommendations aimed at improving coordination on audits, making existing PACE performance information publicly available, and developing a standard national quality measure set for PACE organizations.

In this chapter, we make the following recommendations:

6.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to update audit protocols and three-way program agreements to facilitate joint audits of Program of All-Inclusive Care for the Elderly organizations with state

administering agencies. Audit coordination should include joint planning of audit scopes, sharing documentation requests, and reviewing evidence concurrently, while preserving CMS's responsibility for assessing federal requirements and states' responsibility for assessing state-specific requirements.

6.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to aggregate and publicly release, in a user-friendly format on the CMS website, existing Program of All-Inclusive Care for the Elderly (PACE) performance data, including data PACE organizations submit through CMS's Health Plan Management System as well as enrollee satisfaction data collected as part of PACE organization quality improvement programs pursuant to 42 CFR 460.134(a)(2).

6.3 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend regulations at 42 CFR 460 Subpart H to develop a standardized, national quality measure set for Program of All-Inclusive Care for the Elderly (PACE) organizations. Quality data should be compiled and made publicly available in an accessible format. CMS should follow three key principles when developing a PACE quality measure set: engage stakeholders collaboratively; minimize reporting burden by focusing on the most meaningful measures; and prioritize standardized measures that enable comparability across programs where feasible.

CHAPTER 7: Provider Enrollment and Credentialing in Medicaid

Chapter 7 looks at Medicaid provider enrollment and managed care credentialing, which is designed to ensure that Medicaid enrollees receive care from qualified providers. In addition, these processes are intended to prevent the enrollment of providers who have criminal records related to federal health programs or who have engaged in fraud, waste, or abuse.

The chapter provides an overview of federal requirements for provider enrollment and credentialing in Medicaid, the approaches taken by three states, and challenges for states and providers. It includes insights into barriers faced by certain provider types or challenges related to specific parts of the enrollment and credentialing processes as well as their effects on provider participation, state administrative burden, and program integrity.

Providers seeking to deliver services to Medicaid enrollees and receive payment from the program generally must enroll with the state. Providers seeking to participate in a managed care network must be credentialed by the managed care plan, in addition to enrolling with the state.

Medicaid provider enrollment and credentialing must be rigorous enough to ensure provider quality and program integrity. However, complex and sometimes duplicative requirements may present compliance challenges for states and deter providers from participating in Medicaid. The structure of a state's credentialing system can also have implications for the level of effort required of providers.

The administrative burden of enrollment and credentialing is often most acute for providers in small practices as well as other non-institutional providers who are newer to the Medicaid program and lack administrative support for these processes. Out-of-state providers may experience additional barriers to Medicaid participation when required to enroll and credential with multiple states and managed care plans. Future research could offer additional insight into barriers faced by certain provider types or challenges related to the enrollment and credentialing processes as well as opportunities to mitigate them.

Chapter 1:

Implementing Community Engagement Requirements in Medicaid

Implementing Community Engagement Requirements in Medicaid

Recommendation

1.1 The Secretary of the U.S. 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 (CE) requirements in Medicaid. The monitoring plan should provide insight into how such policies affect eligibility and enrollment. CMS should identify new metrics for state reporting and build upon existing data collection to minimize administrative burden. The evaluation plan should outline, at a minimum, CMS's approach to evaluating the effect of CE requirements on employment, health, and state and federal administrative and program spending. CMS should ensure timely publication of monitoring and evaluation results to inform policy and operational decision making.

Key Points

- Beginning on January 1, 2027, states, for the first time, will be required to make Medicaid eligibility for certain applicants and existing beneficiaries contingent on their participation in qualifying community engagement (CE) activities, pursuant to Public Law 119-21, an Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 (2025 Budget Reconciliation Act).
- Before enactment of the 2025 Budget Reconciliation Act, states could use Section 1115 demonstrations to implement work and CE requirements. Though few states fully implemented CE requirement demonstrations, early data provided insight into enrollment effects and administrative spending associated with implementation.
- MACPAC identified principles for implementing community engagement requirements in four areas: the need for timely guidance, ensuring coverage of eligible individuals, prioritizing efficiency in information technology systems updates, and the need for timely monitoring and evaluation.
- Implementation of CE requirements will require substantial effort and resources from the Centers for Medicare & Medicaid Services (CMS) and states, and will affect Medicaid eligibility and enrollment moving forward.
- The 2025 Budget Reconciliation Act did not establish requirements for monitoring or evaluating implementation of CE requirements.
- CMS has the authority to collect and publish data for monitoring and evaluation, which the agency previously exercised in response to major policy changes, such as the public health emergency unwinding.
- Monitoring can help identify changes in eligibility and enrollment associated with CE requirements, and evaluation would provide insight into how CE requirements affect employment, health, and other outcomes of interest. Monitoring and evaluation can also help identify the need for policy and operational adjustments, and identify effective practices that other states may wish to replicate.

CHAPTER 1: Implementing Community Engagement Requirements in Medicaid

For the first time, states will be required to make Medicaid eligibility for certain applicants and existing beneficiaries contingent on their participation in qualifying community engagement (CE) activities pursuant to Public Law 119-21, an Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 (2025 Budget Reconciliation Act). Operationalizing these requirements will be a considerable undertaking for states, particularly in the timeline the statute provides for implementation. States are also in the midst of implementing other substantial changes to their Medicaid programs established by the same law, including more frequent eligibility redeterminations for adults in the expansion group, referred to as the new adult group, and new limits on their ability to finance the non-federal share.[1]

To identify considerations for implementing CE requirements, MACPAC conducted stakeholder interviews between June and August 2025, when Congress was considering and then approved the 2025 Budget Reconciliation Act.[2] Interviewees provided policy as well as operational insights, including from prior state implementation of similar policies under Section 1115 demonstration authority. The Commission also hosted two panel discussions in the fall of 2025 to gain additional insights from state and federal officials and other experts.[3]

Based on the evidence gathered through stakeholder interviews and expert panels, the Commission identified four principles and a recommendation for implementing CE requirements, which are intended to inform the ongoing work of states and the Centers for Medicare & Medicaid Services (CMS). The following principles reflect the findings from our research and complement the recommendation:

- CMS should provide timely federal guidance and technical assistance to states.
- CMS and states should ensure that eligible individuals can gain and maintain coverage.
- CMS and states should prioritize efficiency when procuring, updating, and operating state information technology (IT) systems.
- CMS and states should use timely monitoring and evaluation data to inform policy and operations.

MACPAC's research findings underscore the importance of transparent monitoring and evaluation of CE requirements in Medicaid. As a result, the Commission recommends the following:

1.1 The Secretary of the U.S. 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 (CE) requirements in Medicaid. The monitoring plan should provide insight into how such policies affect eligibility and enrollment. CMS should identify new metrics for state reporting and build upon existing data collection to minimize administrative burden. The evaluation plan should outline, at a minimum, CMS's approach to evaluating the effect of CE requirements on employment, health, and state and federal administrative and program spending. CMS should ensure timely publication of monitoring and evaluation results to inform policy and operational decision making.

To provide context for the recommendation, this chapter presents findings from stakeholder interviews and expert panels as well as MACPAC's review of the literature. The chapter begins with background on CE requirements in Medicaid and an overview of the statutory requirement in the 2025 Budget Reconciliation Act. Then it outlines the Commission's principles and corresponding considerations for implementing CE requirements as supported by the research. The chapter concludes with a discussion of the Commission's recommendation for monitoring and evaluation.

MACPAC developed this chapter before CMS published its statutorily required interim final rule (IFR) on CE requirements. As such, the chapter does not describe the contents of the IFR or the extent to which the IFR addresses the Commission's recommendation and other considerations that emerged from our stakeholder interviews.

Background

Although work requirements are a long-standing feature of certain low-income benefit programs, such as the Temporary Assistance for Needy Families (TANF) block grant and the Supplemental Nutrition Assistance Program (SNAP), there has been limited use of such requirements in Medicaid.[4] Before enactment of the 2025 Budget Reconciliation Act, Section 1115 demonstrations were the only way for states to condition Medicaid eligibility on completion of specified work and CE activities.[5,6] Several states have used Section 1115 demonstration authority to propose or establish work and CE requirements in recent years. However, legal challenges, changing federal policy priorities, and other factors prevented most of these states from receiving CMS approval or fully implementing their demonstrations.

Section 1115 demonstrations

In 2018, CMS issued guidance inviting states to design Section 1115 demonstrations that made work and CE requirements a condition of Medicaid eligibility for certain beneficiaries. In the guidance, CMS highlighted evidence suggesting that addressing certain determinants of health, such as employment, could improve health outcomes and described the agency's long-standing work with states to support employment, particularly for beneficiaries with disabilities.[7] CMS posited that the ability of these programs to increase beneficiary earnings and participation in job training and work referral programs suggested that other incentives, including work and CE requirements, could yield similar outcomes. Although CMS noted this as a shift in agency policy, it described the new approach as "anchored in historic CMS principles that emphasize work to promote health and well-being" (CMS 2018).

Between 2018 and 2020, CMS approved Section 1115 work and CE demonstrations in 13 states.[8] These demonstrations required (or require, in the case of Georgia's ongoing demonstration) certain non-disabled, non-elderly, non-pregnant individuals to meet work and CE requirements as a condition of Medicaid eligibility. Although the details of their programs varied, states that pursued these policies generally shared the expectation that work and CE requirements would lead to improved beneficiary health and well-being through increased self-sufficiency and reduced reliance on public programs, which would in turn improve the fiscal sustainability of Medicaid. However, due to legal challenges and shifting federal and state priorities, only two states—Arkansas and Georgia—implemented their work and CE programs for more than a few months.[9] Although Arkansas's demonstration was halted by the courts, Georgia's demonstration continues through the end of 2026 (Box 1-1).[10,11]

Arkansas, Georgia, Indiana, Kentucky, New Hampshire, and Wisconsin proceeded far enough in their demonstrations to provide early insight into the anticipated enrollment effects and administrative spending associated with implementing work and CE requirements. Observed and projected coverage losses were substantial and often affected beneficiaries who were already meeting the requirements or should have been exempt (Sommers et al. 2020, HHS 2019). Lack of awareness and communication about the requirements, substantial barriers to employment (e.g., lack of transportation), and administrative barriers to beneficiary reporting were among the most common reasons for non-compliance (ASPE 2021). Moreover, the Government Accountability Office (GAO) found that administrative costs in five states varied considerably, ranging from less than $10 million in New Hampshire to more than $250 million in Kentucky (GAO 2019).[12] Costs varied based on several factors, including the length of demonstration at the time of the study, the number of individuals subject to the requirements, and planned Medicaid IT systems changes. More recently, GAO found that Georgia spent a total of $54.2 million in administrative expenditures to support implementation of its work and CE demonstration (GAO 2025).

BOX 1-1. Arkansas's and Georgia's Work and Community Engagement Demonstrations

Arkansas implemented its Section 1115 work and community engagement (CE) demonstration, Arkansas Works, in June 2018. By December 2018, more than 18,000 beneficiaries were disenrolled because they did not comply or report their compliance with work and CE requirements (DHS 2018). Studies showed that many beneficiaries did not know if they were subject to the requirements and how to demonstrate compliance (DHS 2025). Inadequate beneficiary outreach and administrative challenges, such as trouble accessing the online portal for reporting compliance, created additional barriers to beneficiaries retaining coverage (Hill and Burroughs 2019).

Georgia launched its Section 1115 work and CE demonstration, Pathways to Coverage, in July 2023 and received Centers for Medicare & Medicaid Services approval for a temporary extension through December 2026 (CMS 2025b). Pathways was the first demonstration to apply work and CE requirements to new applicants as well as existing beneficiaries. Enrollment in the first year of the demonstration was lower than expected, according to the state's interim evaluation, which found that of 26,000 applicants, only 4,300 individuals were enrolled, compared to the state's projection of 25,000 (CMS 2026a). Georgia made several changes to address enrollment and administrative barriers identified through the interim evaluation, including reduced frequency of beneficiary compliance reporting and the addition of two new qualifying work activities (GDCH 2025).

Overview of CE Requirements

The 2025 Budget Reconciliation Act requires states to implement a CE requirement for beneficiaries in the new adult group and certain other adults with low incomes by January 1, 2027, unless the states receive a time-limited exemption from CMS, as detailed below. Resulting coverage losses are expected to generate substantial federal savings. The Congressional Budget Office (CBO) estimates that 5.3 million fewer people will have insurance in 2034 because of the policy, which would yield an estimated $326 billion in savings over the same period (CBO 2025a, 2025b).[13]

Key provisions

Details of the CE requirement are described below. States are prohibited from waiving any aspects of the requirement under Section 1115 demonstration authority. The law requires the U.S. Department of Health and Human Services (HHS) to issue an IFR to implement the requirements by June 1, 2026.[14]

Individuals subject to the requirement. The law requires states to implement CE requirements for individuals who are applying for or enrolled in the new adult group under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) as well as individuals who are applying for or enrolled in a Section 1115 demonstration that provides minimum essential coverage to individuals who are age 19–64, not pregnant, not dually eligible for Medicare, and not otherwise eligible for coverage under the state plan.[15]

Required CE activities. To enroll in Medicaid and maintain eligibility, individuals must participate in 80 hours of work, a work program, community service, education, or a combination thereof or be enrolled in an education program at least half-time in a given month.[16] Individuals are also compliant if they have a monthly income that is equal to or above the federal minimum wage requirement multiplied by 80 hours.[17] For seasonal workers, average monthly income is assessed for the previous six-month period.[18]

Compliance verification. Individuals subject to the requirement have to demonstrate compliance for up to three consecutive months (as specified by the state) immediately preceding the month in which they apply for coverage and for one or more months (as determined by the state) as part of their eligibility redetermination. States can choose to verify compliance with CE requirements more frequently, such that verification happens more than twice during a 12-month period (e.g., monthly).[19]

States must, in accordance with standards established by the Secretary of HHS (the Secretary), establish processes and use available information (e.g., payroll data) without requiring, where possible, the individual to submit additional information to verify compliance. This practice is commonly referred to as "ex parte verification."

Beneficiary outreach. In accordance with standards specified by the Secretary, states must notify individuals who are subject to the requirements at least three months before the start of the compliance look-back period immediately preceding December 31, 2026, and periodically thereafter. For example, a state that plans to implement the requirements on January 1, 2027, with a three-month compliance look-back would have to notify anyone who is subject to the requirements by June 30, 2026.

Notices must be delivered by regular mail or an electronic format, if chosen by the individual, and provided in one or more additional forms, such as by telephone, text message, website, or other commonly available electronic means, and other forms as the Secretary determines appropriate. States must include information about: (1) how to comply with the requirements, including an explanation of who the requirements apply to; (2) the consequences of non-compliance; and (3) how to report any change in the individual's status that could affect whether they are subject to the requirements.

Non-compliance. If an individual's compliance with CE requirements cannot be verified, the state must provide the individual with a notice of non-compliance that includes information, in accordance with standards specified by the Secretary, about: (1) how to demonstrate compliance, (2) how to demonstrate that the individual is not subject to the requirements, and (3) how to reapply for Medicaid if the individual is disenrolled or their application is denied. Individuals have 30 days from the receipt of the notice to demonstrate that they comply with the requirements or should not be subject to them. Failure to do so results in disenrollment by the end of the month following the 30-calendar-day period (i.e., opportunity to cure) or the denial of the individual's enrollment application. Before disenrolling beneficiaries or denying new applications, the state must determine whether the individual could be enrolled in Medicaid under a different eligibility category (and therefore not subject to the CE requirement). States must also ensure that individuals have the opportunity for a fair hearing (§ 1902(a)(3) of the Social Security Act (the Act)).

Individuals who would otherwise be eligible for Medicaid but are denied enrollment or disenrolled for failure to meet CE requirements are barred from receiving premium tax credits for the purchase of insurance through the exchanges.

Mandatory exclusions. The law identifies specified excluded individuals who are not subject to CE requirements (Box 1-2). These individuals are:

- youth formerly in foster care;
- parents, guardians, caretaker relatives, or family caregivers of a dependent child age 13 years and younger or a disabled individual;
- medically frail or otherwise have special needs, as defined by the Secretary, including individuals:
  - who are blind or disabled;
  - with a substance use disorder or disabling mental health condition;
  - with a physical, intellectual, or developmental disability that substantially impairs their ability to perform one or more activities of daily living; or
  - who have a serious or complex medical condition
- pregnant or entitled to postpartum Medicaid coverage;
- American Indian or Alaska Native;[20]
- veterans with a total disability rating;[21]

- incarcerated;
- meeting TANF work requirements or receiving SNAP benefits and subject to SNAP work requirements; or
- participating in a drug addiction or alcohol treatment program.[22]

Similar to their processes for verifying compliance, states must, in accordance with standards established by the Secretary, use available information such as claims and encounter data to identify exclusions and minimize the need for individuals to report their qualifying conditions or circumstances (i.e., ex parte).

Mandatory exceptions. The law identifies mandatory exceptions for individuals who are subject to CE requirements (Box 1-2). The state must deem compliant individuals who, for all or part of a month, were:

- a specified excluded individual eligible for a mandatory exclusion, as described above;
- younger than age 19;
- entitled to or enrolled in Medicare;
- enrolled in a mandatory categorically needy eligibility group; or
- incarcerated at any point in the three months before the month in question.

Short-term hardship exceptions. States can choose to provide short-term hardship exceptions to individuals who have experienced certain events under procedures established by the state, in accordance with standards specified by the Secretary (Box 1-2). An individual is considered to have experienced a short-term hardship event and is deemed compliant if, for part or all of such month, any of the following conditions apply:

- The individual receives inpatient hospital services, nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services, or such other services of similar acuity (including related outpatient services) as the Secretary determines appropriate.
- The individual lives in a county or equivalent unit of local government affected by a federally declared emergency or disaster.
- The individual lives in a county with a high unemployment rate (at or above the lesser of 8 percent or 1.5 times the national unemployment rate).
- The individual or their dependent must travel outside their community for an extended period to receive medical services necessary to treat a serious or complex medical condition.[23]

BOX 1-2. Overview of Community Engagement Requirement Exclusions and Exceptions

Mandatory exclusions. As described in Section 1902(xx)(9)(A)(ii) of the Social Security Act (the Act), specified excluded individuals are not subject to community engagement (CE) requirements as a condition of eligibility if they meet one of the criteria for any of the listed exclusions.

Mandatory exceptions. As described in Section 1902(xx)(3)(A)) of the Act, individuals with mandatory exceptions are still subject to CE requirements, but states must deem them compliant in a given month if they meet one of the mandatory exception definitions.

Optional short-term hardship exceptions. As described in Section 1902(xx)(3)(B) of the Act, states may provide exceptions to CE requirements for individuals who have experienced certain qualifying events. These individuals would be deemed compliant for the month.

Individuals must request a short-term hardship exception from the state when it is related to their use of acute care or travel outside of their community for medical services, whereas individual requests are not required for states to grant hardship exceptions related to federally declared emergencies or areas with high unemployment. A state must request CMS approval to apply a short-term hardship exception for individuals residing in counties with high unemployment.

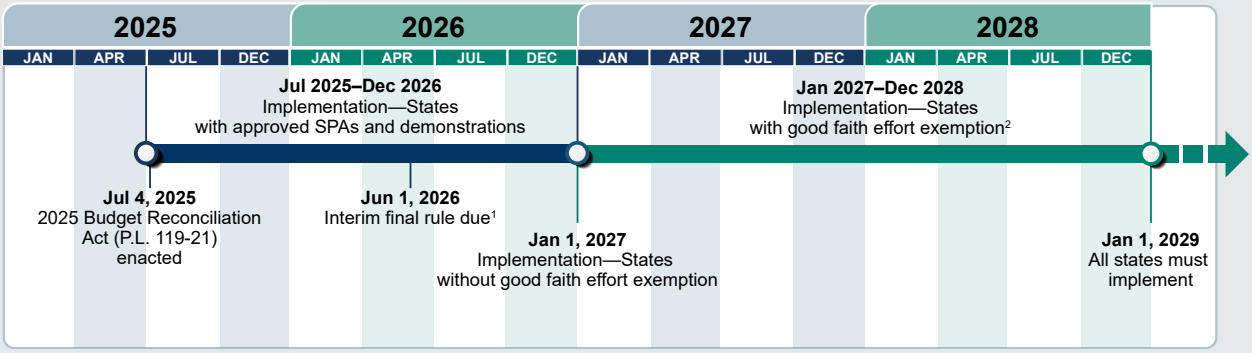
Prohibiting conflicts of interest. States cannot use a Medicaid managed care entity or other specified entity (as defined in Section 1903(m)(9)(D)) of the Act) or other contractor to determine beneficiary compliance with CE requirements unless the contractor has no direct or indirect financial relationship with any Medicaid managed care entity or other specified entity that is responsible for providing or arranging for coverage of Medicaid services for individuals enrolled with the entity under a contract with the state.

Implementation timeline. States may implement CE requirements at different times, contingent on CMS approval (Figure 1-1). The law allows states to implement the requirements before January 1, 2027, via a state plan amendment or Section 1115 demonstration. Additionally, states that demonstrate a good faith effort to implement CE requirements can receive up to two additional years for implementation (through December 31, 2028) if they request and receive the Secretary's approval for an exemption. In reviewing such requests, the Secretary must consider any actions taken by the state toward compliance, any substantial barriers to or challenges in meeting the requirements, the state's detailed plan and timeline for achieving full compliance, and any other criteria established by the Secretary. States granted an exemption must submit quarterly reports on their progress toward full compliance and information on specific risks or new challenges, including plans for mitigating such risks and challenges.

Funding. To establish systems necessary to implement CE requirements and other provisions of the law affecting Medicaid eligibility determinations or redeterminations, the law provides $200 million to the Secretary to make grants to states in fiscal year (FY) 2026. CMS distributed the first half of the funding to the 50 states and the District of Columbia in equal amounts, totaling almost $2 million for each state and the District of Columbia (Mills-Gregg 2026). CMS awarded the other half of the funding based on the number of individuals subject to the requirement in a given state relative to the total number of individuals subject to the requirement in all states as of March 31, 2025 (CMS 2026b).

To support implementation, the law also provides $200 million to the CMS administrator in FY 2026, to remain available until expended.

FIGURE 1-1. Key Dates for Implementing Medicaid Community Engagement Requirements



Notes: SPA is state plan amendment. Demonstration is Section 1115 demonstration. The 2025 Budget Reconciliation Act (P.L. 119-21) is an Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14.

[1] The Secretary of the U.S. Department of Health and Human Services is responsible for issuing the interim final rule.

[2] The statute allows good faith effort exemptions to last through 2028; however, state exemptions will be granted pursuant to Centers for Medicare & Medicaid Services guidance and may extend for a period of less than two years.

Source: MACPAC, 2025, analysis of the 2025 Budget Reconciliation Act.

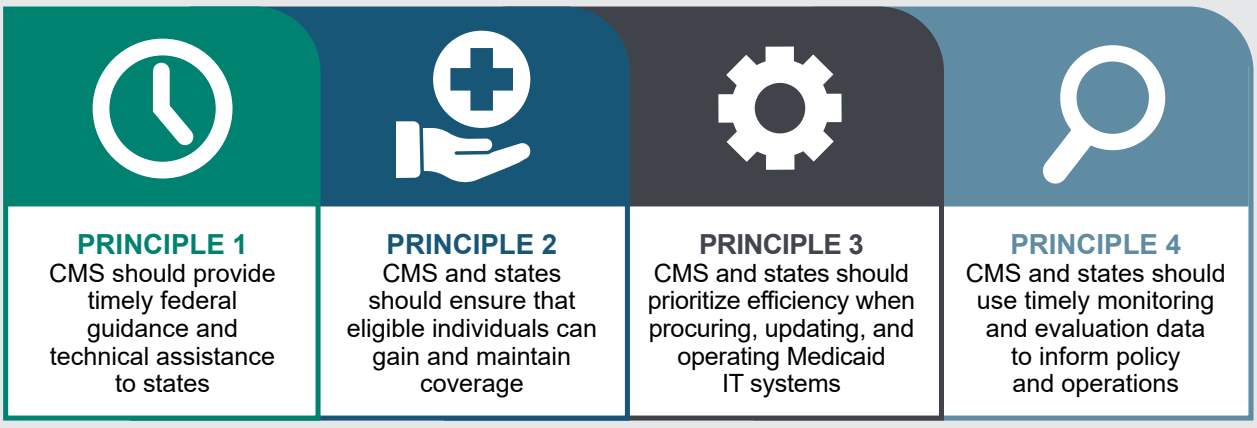
Principles for Implementing CE Requirements

MACPAC's principles for implementing CE requirements reflect the views of the Commission and findings from stakeholder interviews (Figure 1-2). The first principle speaks to the importance of CMS providing states with timely guidance and technical assistance. States are working quickly to implement CE requirements by the statutory deadline and need federal guidance and technical support in several areas. The second principle highlights the importance of CMS and states ensuring that eligible individuals can gain and maintain coverage when CE requirements take effect. The use of ex parte processes and automation will be central to avoiding inappropriate coverage losses by minimizing the need for individuals to report their compliance, exclusion, or exception status. The third principle underscores the importance of CMS and states prioritizing efficiency when procuring, updating, and operating state IT systems, particularly given the magnitude of state and federal spending on systems changes implemented under previous Section 1115 work and CE demonstrations (GAO 2025, 2019). The final principle reflects the view that CMS and states should use timely monitoring and evaluation data to inform policy and operations, and it corresponds to the Commission's recommendation on monitoring and evaluation discussed later in the chapter.

CMS should provide timely federal guidance and technical assistance to states

Early CMS engagement with states is critical to ensuring successful and timely implementation of CE requirements in Medicaid. Among stakeholders interviewed by MACPAC, there was a general recognition that to meet the January 2027 deadline, states would have to initiate key policy, operational, and systems changes well before publication of the IFR in June 2026. Interviewees suggested that CMS provide interim guidance so states could move forward with procurement and other changes that require considerable lead time. At the time of our interviews in the summer of 2025, states noted that they could wait for guidance and risk failing to meet the implementation deadline or could move forward and risk having to make potentially time-consuming and costly changes once CMS guidance is issued. States relayed that simply having a clearer understanding of the topics CMS planned to address in the IFR would help them plan and prioritize more effectively.

FIGURE 1-2. MACPAC's Principles for Implementing Community Engagement Requirements in Medicaid



Note: CMS is Centers for Medicare & Medicaid Services. IT is information technology.

CMS has published limited formal public guidance on CE requirements as of this writing in May 2026, though it has previewed guidance on select topics in state-only forums. An informational bulletin released in December 2025 reiterated the law's requirements and highlighted topics for future CMS guidance. The informational bulletin also offered new insights into CMS's interpretation of the statute regarding compliance verification at renewal. CMS explained that states must deem beneficiaries compliant if, in the period between renewals, they met CE requirements for the number of months specified by the state. States cannot dictate the specific months in which beneficiaries have to demonstrate compliance (CMS 2025a).

In addition to CMS publishing guidance, stakeholders underscored the value of scenario-based forums in which CMS could provide guidance on addressing key challenges that arise in multiple states, such as those convened during the end of the public health emergency (PHE) when states were unwinding the continuous coverage provisions in Medicaid (referred to as "PHE unwinding").[24] Stakeholders described this approach as a highly constructive way to support states. States and other stakeholders also highlighted the role that CMS could play in hosting multistate online forums that enable cross-state learning on topics such as beneficiary outreach. One state Medicaid official said that this type of sharing of effective practices was particularly helpful during the PHE unwinding.

CMS has been hosting regular state-only calls to discuss CE requirement implementation, in addition to providing other types of assistance and technical support. In January 2026, CMS announced that 10 health technology companies with existing Medicaid eligibility and enrollment contracts with states had pledged to offer more than $600 million in no-cost and substantially discounted technology products and services to support CE implementation and broader modernization of Medicaid IT systems (CMS 2026c). CMS is also offering states technical assistance with using Eligibility Made Easy (Emmy), a CMS-developed suite of open-source tools designed to streamline income and CE reporting for Medicaid applicants and beneficiaries (CMS 2026d).

A CMS-developed readiness checklist could help states assess risks and prioritize in a way that best positions them to meet the deadline for CE requirement implementation. Such a tool could be part of CMS's state readiness review process. CMS plans to use the Advanced Planning Document (APD) process to review state readiness to implement CE requirements. CMS reviews and approves APDs, which permit states to obtain enhanced federal matching funds for the design, implementation, and operation of their Medicaid IT systems. CMS described building on the APD review framework by hosting monthly calls with states to discuss the status of their Medicaid IT systems changes as well as other aspects of their implementation efforts, including policy development, staff training, and obtaining state legislative approval (Knapp 2025).

Additional considerations for CMS guidance are discussed below. We address technical assistance pertaining to specific topics, such as Medicaid IT systems, in later sections.

Good faith effort exemptions. States raised questions about the criteria and process for obtaining a good faith effort exemption, which provides additional time for implementation. Some states expressed interest in pursuing an exemption, particularly as they are working to implement other new federal requirements that require simultaneous changes to Medicaid policies, operations, and IT systems. At the time of our interviews in the summer of 2025, CMS officials said they were considering the criteria for good faith effort exemptions and planned to provide additional guidance to states. In other forums, CMS's remarks suggested that the agency anticipates granting a limited number of good faith effort exemptions.

Mandatory exclusions. Interviewees had questions about the criteria for identifying individuals who qualify for mandatory exclusions and noted areas that have a need for CMS guidance (Table 1-1). States were particularly focused on the criteria for medical frailty and expectations for verification, given how substantially CMS guidance on the topic will affect implementation. One state noted that waiting until June 2026 for guidance on medical frailty would not leave enough time to establish policies and modify their systems, including revisions to their application and renewal forms. The state described moving forward with their "best guess" about the definition and potential verification requirements for medical frailty and making modifications as needed to come into alignment with CMS guidance when it is released.

TABLE 1-1. Key Questions about Exclusions Cited by Interviewees

Topic	Key questions
Medical frailty	• What types of medical conditions will qualify an individual for an exclusion on the basis of medical frailty?
Substance use disorder treatment	• What types of substance use disorder treatment will qualify an individual for an exclusion? • How can states ensure that exclusions are made for individuals receiving medications for opioid use disorder?
Caregivers	• Will individuals caring for parents or other adult family members, including those at risk of institutionalization, qualify for an exclusion? • What is the definition of a dependent child?
Compliance with other work requirements	• What will qualify as evidence that an individual is meeting the work requirement in SNAP or TANF? • Will an individual qualify for an exclusion if they are exempt from the SNAP work requirement due to local market conditions?
Verification	• Will CMS specify claims and diagnosis codes for identifying certain exclusions? • Will a medical provider's note suffice for documentation of qualifying conditions? • To what extent will self-attestation be permitted? • How often will an individual's exclusion status be reassessed?

Notes: SNAP is the Supplemental Nutrition Assistance Program. TANF is the Temporary Assistance for Needy Families Program. CMS is Centers for Medicare & Medicaid Services.

Source: MACPAC, 2025, analysis of state and stakeholder interviews conducted between June and August 2025.

Optional short-term hardship exceptions. States and other stakeholders raised questions about the circumstances that will allow an individual to qualify for a short-term hardship exception and the extent to which states will be permitted to rely on self-attestation (Table 1-2). Although some states included certain events, such as bereavement and short-term illness, as qualifying hardships under their previous demonstrations, it is unclear if they will be allowed to do so when implementing CE requirements as described in the law.

It will be important that states have the flexibility to use self-attestation when the data to verify optional short-term hardship exceptions are not available. One state expressed concern about the level of documentation CMS may require from individuals seeking a short-term hardship exception, noting as an example the complications that would arise if local eligibility offices were required to collect documentation of medical service use in a different state. That scenario would require thousands of local office caseworkers to understand the short-term hardship exception policy and implement it appropriately, and it would have implications for the results of the state's payment error rate measurement (PERM) program audits.[25]

Stakeholders also raised questions about the length of the look-back period that states will be permitted to use to calculate the unemployment rate for granting hardship exceptions. This question was not addressed in MACPAC's interview with CMS; however, KFF reported that CMS officials plan to follow subregulatory guidance that already exists in other programs with similar provisions (e.g., SNAP) where possible. Current SNAP regulations allow states to waive work requirements based on 12-month average unemployment rates. KFF found that allowing states to identify counties that meet the criteria for a short-term hardship exception from Medicaid CE requirements using 6-month or 3-month average unemployment rates, in addition to a 12-month average rate, would increase the number of counties that qualify (Bell et al. 2025).

TABLE 1-2. Key Questions about Optional Short-Term Hardship Exceptions Cited by Interviewees

Topic	Key questions
Definition of hardship	• Will states be able to grant short-term hardship exceptions for any of the following events: – major weather issues (e.g., snowstorms); – transportation barriers (e.g., temporarily inoperable vehicle); – bereavement following the death of a family member; – caring for a seriously ill family member; – short-term illness (e.g., flu, COVID-19); or – divorce?
Local market conditions	• Over what period of time will states have to assess the local unemployment rate for granting short-term hardship exceptions?
Verification	• To what extent will self-attestation be permitted for certain short-term hardships (e.g., travel outside the community for medical care)?

Source: MACPAC, 2025, analysis of state and stakeholder interviews conducted between June and August 2025.

Definition of CE. Stakeholders expressed interest in CMS giving states flexibility to further define the criteria for meeting the CE requirement to reflect the various ways in which individuals participate in work, work programs, education, and community service. They raised questions about whether CMS would grant states such flexibility. For example, there appeared to be ambiguity about whether states would be allowed to assess an individual's hours of CE over a period of several months to account for the various factors that might result in a person working more or less than 80 hours in a given month. Similarly, it was unclear if states would be permitted to deem a non-seasonal worker compliant based on the individual's average income over a period of more than one month, as the statute provides them the option to do for seasonal workers.

States and other stakeholders noted that they need further clarity regarding the activities that would qualify as CE. Several interviewees pointed to ambiguity in the definition of the term "work program" and the need for guidance to clarify whether that includes job search activities. There was concern that people who are looking for work, including those who have been laid off, will be unable to gain or maintain Medicaid coverage. This would be a particular issue during an economic downturn that results in substantial job loss.

Some states were also seeking clarity concerning individuals participating in work programs, such as supported employment programs for individuals with behavioral health conditions, who are working toward but not yet meeting the 80-hours-per-month threshold for compliance.

Additionally, states and other stakeholders raised questions about whether activities, such as caregiving, will qualify as community service. This question could be especially relevant for individuals who provide substantial amounts of unpaid care to an elderly parent or other adult (e.g., a neighbor) but may not qualify for the caregiver exclusion.

Ex parte processes. Stakeholders raised questions about CMS's expectations for the use of ex parte verification. As states begin implementing CE requirements, stakeholders suggested they would benefit from guidance that highlights viable data sources and expectations for data recency as well as other potential guardrails related to the use of data matching. One interviewee noted that CMS provided similar guidance during the PHE unwinding, following initial confusion about what data sources could be used for income verification and the parameters for accepting data matches. Requiring states to rely on available data sources could help establish and

maintain eligibility for more people by minimizing the need for individuals to separately verify their compliance or exclusion or exception status. CMS guidance could also identify free or low-cost data sources that states should check (e.g., state quarterly wage data) before paying to access other data sources (e.g., Equifax's The Work Number).

Beneficiary supports. Some stakeholders expressed concern that the law does not require or encourage states to address factors that make it difficult for individuals to participate in CE activities and report their compliance (e.g., lack of transportation or broadband access), noting that this is an area in which CMS guidance could establish relevant expectations. CMS previously required states pursuing work and CE requirements through Section 1115 demonstrations to describe their strategies to help beneficiaries achieve compliance, including their approaches to linking individuals to additional resources for job training or other employment services, child care assistance, transportation, or other work supports (CMS 2018).

Two of the states we interviewed cited a need for CMS to clarify whether federal matching funds will be available for addressing barriers to CE and reporting. The states noted the historic lack of federal matching funds for such supports as a major challenge, particularly in light of increasingly strained state budgets. States with Section 1115 work and CE demonstrations did not receive federal matching funds for these beneficiary supports, though some received matching funds for costs associated with the development of systems that helped connect beneficiaries to employment-related resources and supports (GAO 2019, CMS 2018). States primarily relied on workforce development and other state appropriations, which may be more challenging to obtain in the current fiscal environment.

Opportunity to cure. One stakeholder noted the importance of CMS guidance to address questions about how states will operationalize the requirement that beneficiaries have an opportunity to prove their compliance, exclusion, or exception status when it cannot otherwise be determined by the state. Beneficiaries will have 30 days from receipt of the notice of non-compliance to demonstrate that they meet the requirements or risk losing coverage. However, the law does not specify the period for which a beneficiary must demonstrate their compliance. If a beneficiary is non-compliant in January and receives a notice of non-compliance in February, for example, it is not clear if they can retain eligibility by proving that they were compliant in January or February or either month.

CMS and states should ensure that eligible individuals can gain and maintain coverage

Stakeholders emphasized that states' use of ex parte processes can reduce administrative burden for beneficiaries and, in turn, minimize coverage loss among individuals who meet CE requirements or qualify for an exclusion or exception.[26] Research shows that the administrative burden individuals experience during the application and renewal process can have a substantial effect on their access to Medicaid and other safety net programs (Arbogast et al. 2024, Sommers et al. 2012, Currie 2006). Using available data to renew Medicaid eligibility has been identified as an important tool for reducing churn and coverage loss that occurs when states have insufficient information to determine eligibility (i.e., procedural denials) (Herd et al. 2025; MACPAC 2023, 2021; Ku and Platt 2022).[27]

Limited funding and time for CE requirement implementation will affect the extent to which states can use ex parte and automate data checks.[28] States currently verify income as part of the eligibility determination process; however, many will look to capture more comprehensive information, including income from gig work and self-employment. In addition, states may seek to add data sources or modify their use of existing data (e.g., claims) to make ex parte determinations of compliance, exclusions, and exceptions.

Stakeholders suggested that states prioritize using low-cost, easily accessible data sources that can provide information on a substantial share of their population, including data from other state agencies (e.g., education, corrections). States should also consider modifying the Medicaid application to collect needed information and to obtain beneficiary consent for the release of compliance information (e.g. employment records), if it is not already provided.

When data are not available to determine compliance, stakeholders suggested states provide a user-friendly, consumer-facing portal through which individuals, employers, and community service managers can submit required documentation. Commissioners noted that some systems may have the ability to pull in information from payroll records and other sources to prepopulate forms and reduce administrative burden for Medicaid applicants and beneficiaries. It will be important that states have the flexibility to accept self-attestation, especially for individuals who are new to Medicaid and those participating in community service, for whom existing data may be less readily available.

Identifying mandatory exclusions. Stakeholders identified several data sources for identifying individuals who meet exclusion criteria, including Medicaid applications, enrollment data, claims, and managed care data (Table 1A-1). The data sources and considerations for identifying excluded individuals vary by population, including whether they are newly applying for Medicaid or have prior coverage.

States are more likely to have existing data that can be used to identify exclusions for beneficiaries with prior Medicaid enrollment than they are for individuals with no prior enrollment. Because the Medicaid application functions as an initial source for gathering information on individuals applying for Medicaid, some stakeholders noted that adding targeted questions could help states identify if individuals qualify for an exclusion. States could use claims data to identify individuals with certain medical conditions that indicate they are medically frail or disabled. However, claims data do not always provide timely or reliable information for assessing beneficiaries' functional status for determining disability status. Stakeholders pointed to managed care data, including encounters and case management data, as a more timely and reliable data source. For example, states could use their managed care organization (MCO) case management algorithms to identify excepted population groups, such as pregnant or disabled individuals. One state noted that they are considering using their health information exchange as a real-time data source for identifying some of these populations.

Verifying employment. Verifying traditional employment will pose fewer challenges than verifying non-traditional employment (e.g., gig workers and babysitting), community service, and engagement in multiple qualifying activities. Most states and other stakeholders noted that wage and income data will likely be the primary data sources used to verify employment. States already use wage and income data for determining Medicaid income eligibility; however, implementing CE requirements will require states to use those data in new ways.

The two main data sources identified in our interviews were state quarterly wage data and Equifax's The Work Number (Table 1-3). Quarterly wage data include individual-level, gross income data reported by employers in the state. Many states and stakeholders noted that one of the main advantages of state quarterly wage data is that it is free to states and could cover a sizeable share of the population. However, they also noted that the data are not timely and do not include income from non-traditional employment (e.g., gig work). The Work Number is a database that provides verification services, such as employment and income verification, for commercial and government entities, charging users per query.

Although The Work Number provides more timely and detailed income data (i.e., it is not aggregated and includes deductions) relative to state quarterly wage data, stakeholders consistently raised concerns about the cost to states. For example, the cost of North Carolina Medicaid's Equifax contract nearly doubled in recent years, going from $11.6 million in 2022 to $22.5 million in 2025 (Kliff et al. 2025). Stakeholders also cautioned that The Work Number may not include a large portion of the population in some states.

Several stakeholders noted that the Federal Data Services Hub (the Hub), through which states can access multiple data sources for determining Medicaid eligibility, is a tool that CMS could leverage to offer free or lower-cost access to The Work Number, which would prevent states from having to negotiate individual contracts with Equifax. Currently, states can access The Work Number through the Hub under CMS's national contract, which establishes standardized pricing and query parameters, and states are responsible for their usage costs. One state Medicaid agency official expressed interest in states being able to access The Work Number data without charge under CMS's national contract, as was previously allowed during the PHE unwinding. Another

expert suggested this could be done on a short-term basis as states begin implementing CE requirements to alleviate initial cost pressures and the challenge of establishing ex parte verification of qualifying work activities in a short period of time.

Individuals who are self-employed or engage in gig work often do not receive conventional pay stubs, making their income difficult to verify using traditional wage and income data and requiring states to consider other approaches. Several stakeholders highlighted CMS's consent-based verification application, Emmy, as a way to address these challenges by enabling income reporting for gig and self-employed workers.[29] Emmy and other consent-based verification tools are newer forms of income verification that allow users to log into their personal payroll, bank, or other accounts and consent to sharing their income information with the state, upon the state's request when needed to determine Medicaid eligibility.[30] CMS is piloting Emmy in several states and plans to add modules for CE, such as education and volunteering verification (Singleton and Wagner 2026).

Stakeholders shared several other ideas for employment verification. Some suggested that states or CMS could work with the employers that employ the largest share of Medicaid beneficiaries and develop an automatic feed of needed information with the employees' consent or could create a streamlined process for reporting compliance. In Georgia, beneficiaries use an electronic verification system that can be linked to the employer for employment verification; if the employer is not listed in the system, beneficiaries can upload supporting documentation directly through that system. Another stakeholder suggested the use of e-mail parsing, which is a process of automatically extracting information from e-mails. For example, a beneficiary could e-mail their supporting documentation to a master e-mail address that automatically attributes the information to that beneficiary, reducing the need for manual attribution (this could be a tool for verifying compliance through employment as well as other qualifying activities, including community service).

TABLE 1-3. Summary of Considerations Regarding Most Commonly Identified Wage Data Sources Cited by Interviewees

Attribute	Quarterly wage data	Equifax's The Work Number
Contents	• Individual-level gross income data reported by employers in the state, typically aggregated to the quarter	• Detailed, net income data
Data frequency	• Quarterly (lagged by up to three months)	• Real-time data (though this can vary based on various factors)
Advantages	• Free data source • Could provide data for a sizeable share of individuals	• Timely data • Detailed income information (including deductions)
Limitations	• Data are not timely • Data lack details • Share of individuals included in data can vary • Does not include non-traditional employment	• Costly • Timeliness of data can vary • Share of individuals included in data can vary • Does not include non-traditional employment

Source: MACPAC, 2025, analysis of state and stakeholder interviews conducted between June and August 2025.

Verifying enrollment in education. Stakeholders noted using school enrollment data as one of the main data sources for verifying enrollment in educational programs. Two states shared that they are working with their departments of education to determine what school enrollment data can be shared to verify compliance. In Georgia, the only state with an active work and CE requirement demonstration, one stakeholder noted that beneficiaries can submit their class schedule as evidence to demonstrate compliance with the requirements.

Verifying community service participation. States and other stakeholders generally agreed that verifying community service will be challenging, and a few offered ideas that states may consider. For example, state Medicaid agencies could leverage the processes their judicial systems use for verifying court-mandated community service. Another option noted was accepting beneficiary-submitted documents, such as a calendar noting the days community service was completed or a signed letter from the organization noting the number of community service hours completed as well as a supervisor's contact information for verification.

Self-attestation. It will be important that states have the flexibility to allow individuals to self-attest to their compliance, exclusion, or exception status when data are not immediately available to verify their circumstances. This flexibility will be particularly important for new applicants, for whom the state does not have claims or other information to determine compliance, exclusions, and exceptions, as well as for individuals who participate in community service or non-traditional employment (e.g., babysitting), for which the state cannot access third-party data. Some interviewees noted that self-attestation is an existing practice in the eligibility determination process, and therefore, it should be acceptable for determining CE compliance as well.

Conducting beneficiary outreach. MCOs and community partners can play a critical role in effective beneficiary outreach. One outreach strategy is for states to leverage trusted community organizations such as food banks, community health centers, pharmacies, and faith-based organizations to share information and help beneficiaries navigate the new requirements. Another strategy, which proved effective during the PHE unwinding, is for states to partner with MCOs to obtain more current and reliable beneficiary contact information and to support community outreach efforts.[31] Stakeholders also emphasized the importance of notices written in clear and plain language to promote beneficiary comprehension and urged states to use multiple means of communication to ensure information reaches targeted individuals.

One stakeholder, drawing on experience from the PHE unwinding, highlighted the importance of CMS guidance on allowable outreach activities by states and MCOs, which encourages the use of text messaging, including through platforms such as WhatsApp, to raise awareness about CE requirements and collect needed information from beneficiaries. States have found that some beneficiaries are more likely to respond to text messages than to other communications, such as mail or e-mail (Boozang et al. 2023). Reflecting on the PHE unwinding, the interviewee underscored the efficacy of text messaging and prior confusion around its use, which was later clarified in a ruling by the Federal Communications Commission (FCC 2023).

Assistance with beneficiary reporting. Several stakeholders expressed expectations that states will offer beneficiaries assistance in meeting and reporting their compliance with CE requirements. For example, states could use enrollment assisters, enhanced call center capacity, and application kiosks in public libraries to help individuals complete the application and compliance verification process. This type of assistance is particularly important for older adults who might require more support using technology to submit required documentation. Several stakeholders also suggested that states provide beneficiaries with a list of organizations (for employment or community service opportunities) that have an established verification process with the state.

CMS and states should prioritize efficiency when procuring, updating, and operating Medicaid IT systems

Prior state experience suggests that Medicaid IT systems changes associated with implementing CE requirements will be costly for states and the federal government, which provides enhanced matching funds for the design, development, and implementation of Medicaid IT systems (CMS 2025a).[32] The GAO found that IT systems changes accounted for the largest share of administrative spending for Georgia's Pathways demonstration ($50.8 million out of a total of $54.2 million in administrative expenditures) in FY 2021 through the second quarter of FY 2025. Georgia made a range of changes to its eligibility and enrollment system before and after launching the demonstration, changes that stakeholders noted are likely to be mirrored in other states as they establish processes for determining compliance, exclusions, and exceptions. For example, Georgia added functionality to allow beneficiaries to report engagement in qualifying activities, in addition to automating the verification of some qualifying activities. The state made additional systems changes later on to streamline income verification and other processes (GAO 2025).

The magnitude and cost of required system change will depend, in part, on the state's Medicaid IT infrastructure—for example, whether a state has a legacy or more recently modernized system or if its system is integrated with other human services programs (e.g., SNAP and TANF). To verify compliance and determine exclusions and exceptions, states will need to assess what data they have and what data they need, assess what new functionality is required, and establish the minimum viable product by their implementation date.[33] These decisions will inform what systems changes are feasible by the implementation deadline, including the extent to which states prioritize automation.

States will need greater initial investments of resources and time to incorporate new data sources into their workflows in an automated way, compared to adding a data source that is used for manual verification. For example, a state could have caseworkers manually enter information from a new data source into a beneficiary's record or have their system automatically extract and incorporate information from the data source without requiring manual entry. The Commission's prior work found that automating ex parte processing for renewals can free up staff time for other eligibility-related tasks, such as responding to new applications or processing renewal forms completed by beneficiaries whose eligibility could not be renewed on an ex parte basis. Moreover, increasing automation can reduce the amount of training required to ensure that eligibility case workers understand complex renewal processes; the training typically demands considerable time and investment, especially during periods of high staff turnover (MACPAC 2023).

States and other stakeholders expressed concern that states may not be able to competitively procure a vendor to implement the needed systems changes due to the short implementation timeline, leading to concerns about unfair pricing. States may therefore be limited to using their current vendor to make changes, which could result in higher expenses for lower-quality work.[34] To help mitigate those concerns, stakeholders and states suggested that CMS offer states support in the procurement process to make needed Medicaid IT systems changes. They noted that CMS has a stake in ensuring this process is efficient and cost effective because the federal government will pay an enhanced share of the cost. Several stakeholders suggested that CMS provide states with an estimated cost range for the required systems changes, which could provide helpful parameters for state-vendor negotiations. CMS could leverage the APD process by informing states and vendors that APDs with a scope or cost beyond the expected range will be subject to greater scrutiny and require further justification. During the PHE unwinding, CMS worked with states and vendors to troubleshoot issues, which stakeholders noted that states found helpful.

As noted, CMS published a list of vendors that are offering no-cost and discounted health technology solutions to support CE requirement implementation (CMS 2026c). To help with state procurement of these solutions with transparent pricing, CMS has encouraged states and vendors to consider participating in the General Services Administration Schedule. The General Services Administration Multiple Award Schedule's Cooperative Purchasing Program is a contracting vehicle that states can use to procure products and services from certain vendors through a streamlined process, whereby vendors have agreed to certain prices with prenegotiated terms (CMS 2026e, 2026f).

States and other stakeholders raised additional ideas about the APD process, including whether CMS could streamline it for IT systems changes associated with CE implementation. States have a limited window in which to make changes to their IT systems, and gaining approval of their APDs is a central component of that effort. One expert expressed concern that CMS will not have adequate staff and resources to review and approve APD requests in a thorough and timely manner. Identifying ways to streamline and expedite that process could alleviate resource and time constraints for states as well as CMS. One way to do that could be for CMS to create a template of standard business requirements (i.e., expected system capabilities) that could be shared with vendors to streamline APD approval.

CMS and states should use timely monitoring and evaluation data to inform policy and operations

Reflecting on previous state demonstrations and the PHE unwinding, stakeholders underscored the importance of monitoring to identify and address issues that may contribute to coverage loss among eligible individuals. CMS shared that it intends to monitor CE implementation and is using the experience from PHE unwinding to inform the agency's approach. Several interviewees also highlighted the need for evaluation to assess whether CE requirements further the goals of improving health and increasing employment, particularly given the level of administrative spending that is anticipated for implementing and maintaining the requirements. Although states were required to conduct independent evaluations of their Section 1115 work and CE demonstrations, most demonstrations did not proceed far enough to allow for evaluation results, and findings from other evaluations are limited. Georgia, the only state with existing work and CE requirements, is in the fourth year of its demonstration, and the state's interim evaluation includes findings for the demonstration's first 13 months.[35]

Monitoring and evaluation are distinct activities with different purposes and timing. Monitoring provides ongoing updates on implementation and collects data on process and outcome measures, which may help states and CMS identify whether policy or operational adjustments are needed. Evaluations often take several years and are completed after a policy has been implemented for a specified period; their purpose is to assess whether policies have achieved their goals and to inform decisions about the future of the policy being evaluated (MACPAC 2020a).

CMS and other stakeholders regularly use state-reported data on eligibility operations, enrollment, and service utilization for program monitoring, policy development, and research. States submit these data through a variety of reporting mechanisms, including performance indicator data, eligibility processing data, and the Transformed Medicaid Statistical Information System (T-MSIS).[36] States were first required to submit eligibility processing data during the PHE unwinding to provide insight into their renewal processes and outcomes (CMS 2024c).[37] CMS used eligibility processing data as well as performance indicator and T-MSIS data to publish a monthly snapshot on key eligibility and enrollment metrics during the PHE unwinding. The monthly snapshot provided transparency into states' eligibility operations and enrollment as states resumed routine redetermination activities. CMS continues to publish the monthly snapshot, though it is no longer statutorily required to make public certain monthly data about activities related to eligibility determinations and redeterminations.

Several stakeholders and CMS pointed to the PHE unwinding as a useful model for the development of metrics for monitoring CE requirement implementation. In developing PHE unwinding metrics, CMS reviewed other data states were reporting to prevent duplication, seeking a balance between data needed for monitoring and state reporting burden. Additionally, to ease the submission process, CMS directed states to report these data using the same timelines and platforms they use to submit existing performance indicator data (CMS 2022b).[38] Stakeholders noted that some states made additional data publicly available during the PHE unwinding, including through the development of public-facing dashboards, and states used those data to identify issues and adjust their outreach and other strategies accordingly.

Stakeholders stressed the importance of selecting meaningful metrics and identified several that CMS may consider for state reporting. Table 1-4 lists these potential metrics and their data sources and notes whether the data are currently publicly available.

TABLE 1-4. Potential Metrics for Monitoring Eligibility and Enrollment Effects following Implementation of Medicaid Community Engagement Requirements

Metric category	Proposed metric	Data source	Publicly available?
Call centers	Average call center wait times	PI	Yes
	Average call center abandonment rate	PI	Yes
Applications	Number of applications received	PI, EP	Yes
	Processing time for determinations at application	PI	Yes
	Number of pending applications or redeterminations	PI, EP	Yes
	Total number of individuals determined eligible at application	PI	Yes
	Total number of individuals determined ineligible at application	PI	No
	Total number of individuals determined ineligible at renewal	EP	Yes
	Total number of individuals determined ineligible, by reason for termination (e.g., due to non-compliance with CE requirements)	Not collected[1]	–
Renewals	Number of renewals up for annual redetermination	PI, EP	Yes
	Total number of individuals determined eligible at annual renewal	PI, EP	Yes
	Number of renewals completed on an ex parte basis	EP	Yes
Enrollment	Total Medicaid enrollment	PI, T-MSIS	Yes
	Total Medicaid disenrollment[2]	PI, T-MSIS	Yes
CE	Number of Medicaid beneficiaries subject to CE requirements • Number of Medicaid beneficiaries subject to CE requirements who qualify for an exclusion or exception • Number of Medicaid beneficiaries subject to CE requirements that lose coverage due to non-compliance	Not collected	–
	Number of Medicaid beneficiaries subject to CE requirements who qualify for an exclusion or exception, identified on an ex parte basis • Non-compliance due to not meeting CE requirements • Non-compliance due to not submitting evidence of compliance	Not collected	–
	Number of Medicaid beneficiaries subject to CE requirements satisfying the requirements, total and by each type of qualifying activity (i.e., employment, school, community service, or a combination) • Number of Medicaid beneficiaries satisfying the requirements, verified on an ex parte basis, total and by type of qualifying activity • Number of Medicaid beneficiaries satisfying the requirements, verified manually, total and by type of qualifying activity	Not collected	–

Notes: PI is Medicaid and State Children's Health Insurance Program performance indicator data. EP is Medicaid and State Children's Health Insurance Program eligibility processing data. CE is community engagement. T-MSIS is Transformed Medicaid Statistical Information System. The metrics in this table were recommended by stakeholders and are meant to be illustrative.

– Dash is not applicable.

[1] PI and EP data include information about procedural denials that occur when the state does not have sufficient information but do not provide more specific reasons for why individuals were determined ineligible.

[2] Medicaid disenrollment is not reported as a standalone metric but can be determined by calculating the difference between the enrollment in the month of interest and the prior month.

Sources: MACPAC, 2025, analysis of stakeholder interviews; 2025 PI data dictionary; and 2025 EP data report specifications.

Although the CE-specific metrics would require new state reporting, CMS collects and publishes most of the other suggested metrics (e.g., call centers, applications, and renewals).[39]

Commission Recommendation

The Commission's research findings highlight the importance of monitoring and evaluation to help states and CMS identify needed policy or operational adjustments and to assess whether the requirements further the stated goals of improving health and increasing employment. The Commission therefore recommends that CMS develop a plan for monitoring and evaluating CE requirements.

Recommendation 1.1

The Secretary of the U.S. 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 (CE) requirements in Medicaid. The monitoring plan should provide insight into how such policies affect eligibility and enrollment. CMS should identify new metrics for state reporting and build upon existing data collection to minimize administrative burden. The evaluation plan should outline, at a minimum, CMS's approach to evaluating the effect of CE requirements on employment, health, and state and federal administrative and program spending. CMS should ensure timely publication of monitoring and evaluation results to inform policy and operational decision making.

Rationale

MACPAC's research highlights the need for monitoring changes in eligibility and enrollment following CE requirement implementation. Realized and projected changes in enrollment resulting from Section 1115 work and CE demonstrations in several states suggest that CE requirements can lead to substantial disenrollment of otherwise eligible beneficiaries, including among individuals who meet the requirements or qualify for an exclusion or exception. Monitoring is needed to help CMS and states identify trends and areas requiring policy or operational adjustments to mitigate coverage loss among eligible individuals. Monitoring can also assist in identifying effective practices that other states may wish to replicate.

The 2025 Budget Reconciliation Act did not establish requirements for monitoring implementation of CE requirements. CMS has the authority to collect and publish data for program monitoring and has previously exercised this authority in response to major policy changes, such as the PHE unwinding.[40] CMS indicated that the agency is developing a monitoring plan that will leverage existing metrics and data and include new CE-specific metrics. However, as of May 2026, CMS has not publicly released details of the plan, and it was unclear if those plans or resulting state reporting would be made public.

With input from states, beneficiaries, and other stakeholders, CMS should develop and make public a monitoring plan that includes new, meaningful metrics for tracking changes in eligibility and enrollment associated with CE requirements, such as those suggested by stakeholders in Table 1-4. Although states already submit eligibility and enrollment data, additional publicly reported metrics are needed to track CE requirement compliance and exceptions and the extent to which such determinations are made ex parte. It will also be critical to monitor procedural denials and disenrollment among individuals subject to CE requirements, which can indicate whether individuals are facing administrative barriers to completing the application or redetermination process (e.g., difficulty using online portals for reporting their compliance). Tracking metrics over time and stratifying data by certain characteristics, such as demographic characteristics, eligibility group, and application type (i.e., new applications and renewals), may help identify targeted areas in need of policy or operational adjustments.

CMS should share its monitoring plan in a transparent and timely manner so states have time to modify their IT systems accordingly. To the greatest extent possible and to minimize state burden, CMS should leverage data that are already collected and use existing mechanisms for new state reporting, as they did during the PHE unwinding. Additionally, CMS should make state reporting publicly available on a monthly basis and provide context to aid interpretation, such as

information about state variations that may contribute to differences in reporting.

Although monitoring can help identify needed policy and operational adjustments, a federally led evaluation would provide insight into how CE requirements affect employment, health, and other outcomes of interest. Policies that make participation in work and other CE activities a condition of Medicaid eligibility are relatively new and have not been widely evaluated. Among other outcomes, CMS should evaluate the extent to which CE requirements contribute to churn as well as changes in health care access and health status among individuals who are disenrolled and later reenrolled in Medicaid. CMS should also consider approaches to assessing health status, employment, and coverage among individuals who were disenrolled due to CE requirements and did not later return to Medicaid.

Evaluation is also needed to assess state and federal administrative spending associated with implementing and maintaining CE requirements, which prior experience suggests will be substantial. Local government spending should also be considered in states where counties or municipalities are responsible for processing Medicaid applications and renewals. In these instances, local governments will have to invest additional resources to hire and train staff, upgrade IT systems, update policies and procedures, and implement other changes to operationalize CE requirements. Tracking administrative spending will help policymakers consider the cost-effectiveness of CE requirements by providing insight into the financial investment required to operationalize them relative to any realized gains in employment or other potential benefits.

CMS has the authority to evaluate Medicaid policies and is developing a plan for evaluating CE requirements. States may choose to sponsor independent evaluations of CE requirements in their states; however, it is unclear how many will do so. Designing and carrying out a rigorous evaluation requires staff and financial resources, and such state efforts may be limited by competing priorities and increased budget pressures. In addition, states often experience methodological and administrative challenges in carrying out rigorous evaluations, despite federal efforts to improve the quality of state-led evaluations (MACPAC 2020a).[41]

HHS has conducted federal evaluations of state policy changes and can draw on that experience to evaluate the effect of CE requirements. In doing so, HHS should solicit stakeholder input and consider past evaluation approaches, such as the meta-analytic approach used for evaluating Section 1115 substance use disorder and serious mental illness or serious emotional disturbance demonstrations under contract with qualified health services researchers. This approach would allow CMS to assess whether CE requirements are meeting the desired goals in the states selected for study and provide insight into state variations that may contribute to different outcomes. These evaluation efforts would be aided by HHS's timely access to certain federal data sources, such as T-MSIS and employment data from the Internal Revenue Service.

In addition to carrying out and making public the results of a full-scale, multiyear evaluation, CMS should prioritize the development and publication of rapid cycle evaluation reports that provide timely, actionable insights to support continuous improvement. For example, these reports could examine how states make the CE requirements operational (e.g., their processes for determining medical frailty and data sources used to verify compliance) and consider the relationship between state policies and relevant process measures, such as rates of ex parte and procedural terminations. Other reports could focus on the experience of individuals subject to CE requirements to understand factors that contribute to the successful fulfillment of CE requirements as well as coverage denial and termination. Rapid cycle evaluation could also examine the implications of CE requirements on MCOs and safety net providers, particularly in rural areas. It will be important to understand how the requirements affect the stability of providers (e.g., by assessing levels of uncompensated care or bad debt) as well as MCOs, which may experience changes in the risk profile of their enrolled members.

Implications

Federal spending. The CBO estimates this recommendation would increase federal direct spending by less than $10 million over a 10-year period. The increase in spending would be associated with the federal match for administrative costs associated with states collecting data in standardized formats and reporting new metrics.

States. This recommendation would require states to collect and submit additional data to CMS. CMS could elect to use existing reporting mechanisms to minimize state reporting burden. Additionally, data collected and reported for monitoring could support states in their own monitoring and program improvement efforts.

Enrollees. This recommendation would not have a direct effect on enrollees. However, this recommendation could help safeguard coverage for eligible individuals by enhancing state and federal monitoring of eligibility and enrollment trends that might signal coverage loss or inability to gain coverage among individuals who meet or should not be subject to CE requirements. Also, evaluation of CE requirements, particularly rapid cycle evaluation reports, could help states and CMS identify and address issues that affect coverage.

Plans. This recommendation would not have a direct effect on managed care plans. However, managed care plans may benefit from increased transparency into eligibility and enrollment trends that affect their business model.

Providers. This recommendation would not have a direct effect on health care providers. However, providers may benefit from transparent monitoring of eligibility and enrollment changes to the extent that such activities help CMS and states ensure that individuals who are eligible for Medicaid can gain and maintain coverage.

Looking Ahead

Implementation of CE requirements will require substantial effort and resources from CMS and states and will affect Medicaid eligibility and enrollment moving forward. The Commission will continue to monitor federal and state activities related to CE requirements in Medicaid and identify areas in which additional analysis may inform policymakers.

Endnotes

[1] Beneficiaries in the new adult group are individuals age 19–64 with incomes up to 133 percent of the federal poverty level who are eligible to enroll under the state plan in the adult group described in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act). Section 71107 of the 2025 Budget Reconciliation Act requires states to redetermine eligibility for individuals in the adult expansion group every six months.

[2] MACPAC conducted 22 interviews between June and August 2025. Interviewees included representatives from the Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, national associations, beneficiary advocacy organizations, and vendors as well as subject matter experts from think tanks, academia, and consulting firms.

[3] The expert panels included two Medicaid directors, an enrollment assister, a Medicaid systems expert, and representatives from CMS and the National Association of Medicaid Directors.

[4] TANF provides cash assistance and other benefits and services to families with low incomes. Most adults in the program are required to work or participate in related activities, such as job search or training (Falk 2023). SNAP is a much larger program than TANF that helps individuals and households with low incomes purchase food. Relative to TANF, fewer adults in SNAP are subject to work requirements; however, the 2025 Budget Reconciliation Act expands the SNAP work requirement by applying it to older adults and parents and caregivers of dependents age 14 and older and by restricting states' abilities to waive the requirement in areas with high unemployment (NACo 2025, CBO 2022).

[5] Several optional Medicaid eligibility groups, such as Medicaid buy-in, condition Medicaid eligibility for certain beneficiaries with disability on earned income (Balanced Budget Act of 1997, P.L. 105-33; Ticket to Work and Work Incentives Improvement Act of 1999, P.L. 106-170).

[6] Section 1115 of the Act provides the federal government with broad authority to waive federal Medicaid requirements to allow states to make changes to their Medicaid programs. Specifically, this authority allows the Secretary of the U.S. Department of Health and Human Services (the Secretary) to waive most of the requirements under Section 1902 of the Act to the extent necessary to enable a state to carry out an experimental, pilot, or demonstration project that the Secretary deems likely to assist in promoting the objectives of Medicaid.

[7] Examples include Medicaid buy-in programs that allow workers with disabilities to earn higher incomes and still maintain Medicaid coverage, voluntary work and job-training referral programs, and other employment supports. These eligibility groups were established with the goal of preserving the Medicaid eligibility of individuals who would otherwise lose coverage due to their earned income. Historically, participation has been optional (i.e., not a requirement of eligibility) and focused on people with disabilities or people who are receiving home- and community-based services under state plan authority in Section 1915(c) or Section 1915(i) of the Act (CMS 2018).

[8] The 13 states with approved demonstrations were Arizona, Arkansas, Georgia, Indiana, Kentucky, Maine, Michigan, Nebraska, New Hampshire, Ohio, South Carolina, Utah, and Wisconsin.

[9] Arkansas and Georgia were the only two states that implemented their demonstrations for more than a few months due to litigation and the Biden administration's decision to rescind approval for work and CE demonstrations. A federal judge allowed Georgia's Pathways to Coverage demonstration to proceed because it applies work and CE requirements to a newly eligible population. Georgia's demonstration is the only one still in operation.

[10] In March 2019, the U.S. District Court for the District of Columbia vacated CMS's approval of the Arkansas Works demonstration and remanded it to CMS for further review. The U.S. Court of Appeals for the District of Columbia Circuit upheld that decision in February 2020. The Biden administration later withdrew CMS's approval of Arkansas's demonstration.

[11] The data on Georgia's demonstration in Box 1-1 are from the interim evaluation report prepared by the Public Consulting Group in December 2024, which provides application and enrollment information from the first year of Georgia's Pathways to Coverage demonstration (CMS 2026a).

[12] The five states that the GAO examined were Arkansas, Indiana, Kentucky, New Hampshire, and Wisconsin. The GAO examined administrative spending from the start of each demonstration (between 2016 and 2018, depending on the state) through 2018 (GAO 2019).

[13] Other estimates of potential coverage losses are higher than those provided by the CBO. The Center for Budget and Policy Priorities, for example, estimates that 7.1 million fewer people will have coverage in 2034 as a result of Medicaid CE requirements (Zhang and Lukens 2025).

[14] IFRs are promulgated without advanced notice and comment. Agencies solicit public comment after publishing the IFR, which may go into effect as soon as 30 days later. The agency subsequently issues a final rule that may reflect public feedback (Nielsen 2023).

[15] Minimum essential coverage is defined in Section 1902(xx)(9)(A)(i)(II)(aa) of the Act. CMS is evaluating which populations enrolled through a Section 1115 demonstration will be subject to CE requirements, beyond those in Georgia and Wisconsin (CMS 2025a).

[16] An educational program includes an institution of higher education, as defined in Section 101 of the Higher Education Act of 1965 (P.L. 89-329), and a program of career and technical education, as defined in Section 3 of the Carl D. Perkins Career and Technical Education Improvement Act of 2006 (P.L. 109-270). A work program, defined in Section 6(o)(1) of the Food and Nutrition Act of 2008 (P.L. 88–525), includes certain approved federal, state, and veteran employment and training programs but excludes job search–only programs.

[17] The federal minimum wage at the time of this writing in May 2026 is $7.25 per hour, and the income threshold for meeting the 80-hour requirement is $580.

[18] Seasonal worker, defined in Section 45R(d)(5)(B) of the Internal Revenue Code of 1986 (P.L. 99-514), is a worker who performs labor or services on a seasonal basis, as defined by the Secretary of Labor, and retail workers employed during holiday seasons.

[19] Section 71107 of the 2025 Budget Reconciliation Act requires states to redetermine eligibility for individuals in the adult expansion group every six months. Unlike the CE requirement, the six-month renewal requirement does not apply to states that cover a portion of the expansion population through a waiver (e.g., Georgia and Wisconsin).

[20] This includes American Indian or Alaska Native individuals who meet one of the following criteria: is an Indian or an Urban Indian (as defined in paragraphs (13) and (28) of §4 of the Indian Health Care Improvement Act (P.L. 94-437)), is a California Indian (as described in §809(a) of such act), or has otherwise been determined eligible as an Indian for the Indian Health Service under HHS regulations (CMS 2025a).

[21] Specified excluded individuals include veterans with a total disability rating (38 USC § 1155). A total (100 percent) disability rating is the highest rating assigned by the U.S. Department of Veterans Affairs for service-connected compensation purposes. This rating is reserved for veterans with extremely debilitating service-connected conditions, which typically make them unable to work and care for themselves. Veterans must meet strict criteria to qualify for this rating (Chisholm Chisholm & Kilpatrick 2026).

[22] An individual must be participating in a drug use disorder or alcohol use disorder treatment and rehabilitation program as defined in Section 3(h) of the Food and Nutrition Act of 2008, which means any such program conducted by a private nonprofit organization or institution or a publicly operated community mental health center under part B of Title XIX of the Public Health Service Act (42 USC. § 300x et seq.) to provide treatment that can lead to the rehabilitation of individuals with drug use disorder or alcohol use disorder.

[23] The term "serious or complex medical condition" is not defined in reference to hardship exceptions or the definition of a specified excluded individual.

[24] During the PHE, the Families First Coronavirus Response Act (P.L. 116-127) provided states with a temporary increase in the federal medical assistance percentage (FMAP) if they met certain conditions, including a continuous coverage requirement for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020. The Consolidated Appropriations Act, 2023 (P.L. 117-328) decoupled the end of the continuous coverage requirement from the PHE and established March 31, 2023, as the end of the continuous coverage requirement, after which time states would need to begin redetermining eligibility for Medicaid beneficiaries.

[25] The purpose of the payment error rate measurement (PERM) program is to measure and report an unbiased national improper payment rate for Medicaid and the State Children's Health Insurance Program (CHIP) as required by federal law. PERM counts a payment as an error if the payment or eligibility decision did not comply with applicable federal regulations and state policies. Improper payments include both expenditures that should not have occurred and instances in which insufficient or no documentation is available to support the payment or eligibility decision as proper (MACPAC 2020b). Improper payments are erroneous but are not necessarily the result of fraud.

[26] Administrative burden for individuals includes three components: (1) learning costs, including time and effort needed to learn about a program and how to gain access; (2) compliance costs, including the provision of information and documentation to demonstrate eligibility; and (3) psychological costs, including stress that arises from uncertainty about one's ability to navigate the eligibility process (Herd and Moynihan 2025).

[27] "Churn" refers to a short-term break in coverage wherein a beneficiary is disenrolled from the program and then reenrolled shortly thereafter (often measured within a 12-month time frame). Churn can be an indicator of administrative barriers that disrupt coverage for beneficiaries who continue to meet income and other eligibility requirements (MACPAC 2021).

[28] For Medicaid renewals, some states currently use fully automated data checks, in which computer programs automatically connect to electronic data sources and compare results to the applicable income and asset thresholds. However, full automation is not required to achieve a high rate of ex parte renewals. Some states using a combination of manual and automatic procedures have been able to renew more than 50 percent of their Medicaid beneficiaries via ex parte processing (Brooks et al. 2023, MACPAC 2023).

[29] Emmy was previously known as "Income Verification as a Service," or "IVaaS."

[30] In addition to Emmy, other consent-based verification options include Argyle, Digital Consent-based Income Tool by Digital Public Works (now called Verify My Income), Income Passport by SteadyIQ, and Truv (Singleton and Wagner 2026).

[31] Relatedly, 32 states received time-limited authority under Section 1902(e)(14)(A) of the Act during the PHE unwinding to accept updated beneficiary contact information from managed care plans without first contacting the beneficiary to confirm the accuracy of the updated information (CMS 2024a, 2022a).

[32] Consistent with long-standing Medicaid law, states may receive enhanced federal matching funds for costs associated with their Medicaid IT systems, including changes necessitated by CE requirements. CMS will provide a 90 percent match for the design, development, and implementation of IT systems and a 75 percent match for the maintenance and operations of these systems (CMS 2025a).

[33] Minimum viable product is an IT product that meets basic requirements but will continue to be improved to comprehensively meet states' requirements.

[34] Without competition, vendors may not feel the pressure to offer the best price, and states would lose the opportunity to consider other vendors that may be better positioned to meet the state's objectives.

[35] The interim evaluation report prepared by the Public Consulting Group in December 2024 provides application and enrollment information from the first year of Georgia's Pathways demonstration. The interim evaluation found that Pathways enrollment was lower than expected; only 4,300 individuals were enrolled compared to the state's projection of 25,000. Among applicants eligible for Pathways, not accounting for the work and CE requirement, 28 percent were denied coverage due to failure to report a sufficient number of hours of participation in a qualifying activity. This percentage was higher (39 percent) among older applicants age 50–64 years (CMS 2026a). A summative evaluation report is due to CMS within 18 months of the end of the demonstration period, currently slated for December 31, 2026 (CMS 2025b, 2024b).

[36] Performance indicator data refer to data from the Medicaid and CHIP Eligibility and Enrollment Performance Indicators project. Eligibility processing data refer to Medicaid and CHIP Eligibility Processing Data.

[37] Section 5131(b) of the Consolidated Appropriations Act, 2023 required that states submit to CMS, and CMS then make public, certain monthly data about activities related to eligibility determinations and redeterminations conducted between April 1, 2023, and June 30, 2024. Although the statutory requirement has since lapsed, CMS continues to require states to report these metrics and then makes them public (CMS 2024a).

[38] States submit monthly performance indicator data on key Medicaid and CHIP operations, including enrollment, total applications, and modified adjusted gross income application processing.

[39] States submit specific metrics to CMS about Medicaid and CHIP renewals initiated and completed for a given month. These metrics support CMS efforts to monitor states' retention and disenrollment of Medicaid and CHIP beneficiaries through the eligibility renewal process. States submitted their first eligibility processing data reports in February, March, or April 2023, depending on the state. These data were used to monitor state unwinding activities (CMS 2025c).

[40] CMS has the authority to collect needed information from states under Sections 1902(a)(4)(A), 1902(a)(6), and 1902(a)(75) of the Act to ensure proper and efficient administration of the Medicaid program.

[41] Prior MACPAC work identified these challenges with respect to Section 1115 demonstration evaluations; however, the methodological and administrative challenges identified are likely also relevant for states evaluating CE requirements under the state plan.

References

Arbogast, I., A. Chorniy, and J. Currie. 2024. Administrative burdens and child Medicaid and CHIP enrollments. *American Journal of Health Economics* 10, no. 2: 237–271. https://www.journals.uchicago.edu/doi/epdf/10.1086/728170.

Arkansas Department of Human Services (DHS). 2025. *Request to amend the ARHOME Section 1115 demonstration project*. Little Rock, AR: DHS. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-ar-home-pa-pathwy-prspty-04102025.pdf.

Arkansas Department of Human Services (DHS). 2018. Arkansas Works program. Little Rock, AR: DHS. https://ccf.georgetown.edu/wp-content/uploads/2019/01/Arkansas-Works-Program-December-2018.pdf.

Bell, C., J. Tolbert, and S. Cervantes. 2025. A look at the potential impact of the high unemployment hardship exception to Medicaid work requirements. Washington, DC: KFF. https://www.kff.org/medicaid/a-look-at-the-potential-impact-of-the-high-unemployment-hardship-exception-to-medicaid-work-requirements/.

Boozang, P., K. Serafi, and A. Dworkowitz. 2023. Federal ruling provides text messaging flexibility to support state's unwinding efforts. Princeton, NJ: State Health & Value Strategies. https://shvs.org/federal-ruling-provides-text-messaging-flexibility-to-support-states-unwinding-efforts/.

Brooks, T., A. Gardner, P. Yee, et al. 2023. Medicaid and CHIP eligibility, enrollment, and renewal policies as states prepare for the unwinding of the pandemic-era continuous enrollment provision. Washington, DC: KFF. https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-prepare-for-the-unwinding-of-the-pandemic-era-continuous-enrollment-provision/.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2026a. Letter from Danielle Daly to Stuart Portman regarding approval of the Georgia Pathways demonstration program interim evaluation report. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ga-pathway-to-covrg-monitor-interm-evltn-rpt-12302024.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2026b. Centers for Medicare & Medicaid Services Medicaid & CHIP All-State Call and Webinar. March 24, 2026. Baltimore, MD: CMS. https://www.medicaid.gov/resources-for-states/downloads/covid19transcript03242026.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2026c. Medicaid technology companies pledge $600M in savings to support community engagement and related state Medicaid system improvements. January 29, 2026, press release. Baltimore, MD: CMS. https://www.cms.gov/newsroom/press-releases/medicaid-technology-companies-pledge-600m-savings-support-community-engagement-related-state.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2026d. Eligibility made easy. Baltimore, MD: CMS. https://www.cms.gov/medicaid-chip/community-engagement-support/eligibility-made-easy.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2026e. *Expanding state access to technology and IT systems vendors to support Medicaid community engagement*. Baltimore, MD: CMS. https://www.medicaid.gov/resources-for-states/working-families-tax-cut-legislation/community-engagement/exp-st-acc-tech-it-sys-ven-sup-med-comm-eng-fact-sheet.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2026f. *Expanding vendor access to state government agencies*. Baltimore, MD: CMS. https://www.medicaid.gov/resources-for-states/downloads/exp-vendor-access-factsheet.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2025a. Center for Medicaid & CHIP Services informational bulletin regarding "Section 71119 of the 'Working Families Tax Cut' legislation, Public Law 119-21: Requirements for states to establish Medicaid community engagement requirements for certain individuals." December 8, 2025. https://www.medicaid.gov/federal-policy-guidance/downloads/cib12082025.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2025b. Letter from Karen Llanos to Stuart Portman regarding approval of temporary extension and amendment of Georgia's Section 1115 Pathways to Coverage demonstration. September 23, 2025. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ga-pathway-to-covrg-cms-tmpry-extn-aprvl-09232025.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2025c. *Medicaid and Children's Health Insurance Program eligibility processing data report specifications*. Baltimore, MD: CMS. https://www.medicaid.gov/media/136536.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024a. COVID-19 PHE unwinding full table waiver chart. Baltimore, MD: CMS. https://www.medicaid.gov/resources-for-states/downloads/covid19-phe-unwinding-full-table-waiver-chart.xlsx.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024b. Letter from Danielle Daly to Stuart Portman regarding approval of Georgia's evaluation design. November 14, 2024. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ga-pathway-cvrge-cms-aprvd-evltn-dsgn-stcs.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024c. Letter from Daniel Tsai to state health officials regarding "Continuation of certain Medicaid and CHIP eligibility processing data reporting." May 30, 2024. Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/sho24002.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022a. Letter from Daniel Tsai to state health officials regarding "Promoting continuity of coverage and distributing eligibility and enrollment workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) upon conclusion of the COVID-19 public health emergency." March 3, 2022. https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022b. The Coverage learning collaborative: Medicaid and Children's Health Insurance Program (CHIP) eligibility and enrollment unwinding data reporting & submission. Baltimore, MD: CMS. https://www.medicaid.gov/resources-for-states/downloads/unwinding-data-training-slides.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018. Letter from Brian Neale to state Medicaid directors regarding "Opportunities to promote work and community engagement among Medicaid beneficiaries." January 11, 2018. https://web.archive.org/web/20180305045935/https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf.

Chisholm Chisholm & Kilpatrick, LTD. 2026. What does it mean to be rated 100% disabled by VA? https://cck-law.com/types-of-va-disabilities/what-does-it-mean-to-be-100-percent-disabled-by-the-va/.

Congressional Budget Office (CBO). 2025a. CBO's estimate of annual changes in the number of people without health insurance under Title VII, Public Law 119-21. Washington, DC: CBO. https://www.cbo.gov/system/files/2025-08/61367-Uninsured-Data.xlsx.

Congressional Budget Office (CBO). 2025b. Summary: Estimated budgetary effects of Public Law 119-21, to provide for reconciliation pursuant to Title II of H. Con. Res. 14, relative to CBO's January 2025 baseline. Washington, DC: CBO. https://www.cbo.gov/system/files/2025-07/61570-pl119-21-2025Recon-CLB.xlsx.

Congressional Budget Office (CBO). 2022. Work requirements and work supports for recipients of means-tested benefits. Washington, DC: CBO. https://www.cbo.gov/publication/57702.

Currie, J. 2006. Chapter 3: The take-up of social benefits. In *Public Policy and the Income Distribution.* New York, NY: Russell Sage Foundation. https://www.google.com/books/edition/Public_Policy_and_the_Income_Distributio/N_IWAwAAQBAJ?hl=en&gbpv=1.

Falk, G. 2023. *The Temporary Assistance for Needy Families (TANF) block grant: A primer on TANF financing and federal requirements*. Washington, DC: Congressional Research Service. https://sgp.fas.org/crs/misc/RL32748.pdf.

Federal Communications Commission (FCC). 2023. Rules and regulations implementing the Telephone Consumer Protection Act of 1991: U.S. Department of Health and Human Services petition for declaratory ruling. CG docket no. 02-278 (January 23). https://docs.fcc.gov/public/attachments/DA-23-62A1_Rcd.pdf.

Georgia Department of Community Health (GDCH). 2025. Georgia Section 1115 demonstration waiver extension request. Atlanta, GA: GDCH. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ga-pathway-pa-04282025.pdf.

Herd, P., and D. Moynihan. 2025. Administrative burdens in the social safety net. *Journal of Economic Perspectives* 39, no. 1: 129–150. https://www.aeaweb.org/articles/pdf/doi/10.1257/jep.20231394.

Herd, P., E.R. Giannella, J. Barofsky, et al. 2025. Interventions to automate Medicaid renewals reduce procedural denials and increase coverage. *Health Affairs* 44, no. 11. 1336–1343. https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00316.

Hill, I., and E. Burroughs. 2019. *Lessons from launching Medicaid work requirements in Arkansas*. Washington, DC: Urban Institute. https://www.urban.org/sites/default/files/publication/101113/lessons_from_launching_medicaid_work_requirements_in_arkansas_3.pdf.

Kliff, S., M. Sanger-Katz, and A. Elkeurti. 2025. "A big positive": How one company plans to profit from Medicaid cuts. *The New York Times*, November 3, 2025. https://www.nytimes.com/2025/11/03/health/medicaid-cuts-equifax-data.html.

Knapp, M. 2025. Discussion with the Medicaid and CHIP Payment and Access Commission, December 11, 2025. https://www.macpac.gov/wp-content/uploads/2025/12/12-11-25-MACPAC-Public-Session.pdf.

Ku, L., and I. Platt. 2022. Duration and continuity of Medicaid enrollment before the COVID-19 pandemic. *JAMA Health Forum* 3, no. 12: e224732. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2799532.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2023. *Increasing the rate of ex parte renewals*. September 2023. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2023/09/Increasing-the-Rate-of-Ex-Parte-Renewals-Brief.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021. *An updated look at rates of churn and continuous coverage in Medicaid and CHIP*. October 2021. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020a. Chapter 3: Improving the quality and timeliness of Section 1115 demonstration evaluations. In *Report to Congress on Medicaid and CHIP*. March 2020. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2020/03/Improving-the-Quality-and-Timeliness-of-Section-1115-Demonstration-Evaulations.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020b. Payment error rate measurement (PERM). Washington, DC: MACPAC. https://www.macpac.gov/subtopic/payment-error-rate-measurement-perm/.

Mills-Gregg, D. 2026. CMS sends states first round of federal Medicaid work req funding. *Inside Health Policy,* March 9, 2026. https://insidehealthpolicy.com/daily-news/cms-sends-states-first-round-federal-medicaid-work-req-funding.

National Association of Counties (NACo). 2025. One Big Beautiful Bill Act (P.L. 119-21): Supplemental Nutrition Assistance Program (SNAP) administrative and funding changes. July 9, 2025. Washington, DC: NACo. https://naco.sharefile.com/share/view/sce55961de6ec-417faa15406a4ead2256.

New Hampshire Department of Health and Human Services (HHS). 2019. Letter from Jeffrey A. Meyers to Calder Lynch regarding "Notice of temporary delay in implementation of community engagement requirement under waiver no. 11-W-00298/1." July 9, 2019. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/granite-advantage-health-care-program/nh-granite-advantage-health-care-program-temp-delay-20190709.pdf.

Nielsen, T.E. 2023. Interim final rules and the APA: Some rule of law problems. *Harvard Journal of Law & Public Policy.* Fall 2023, no. 50. https://journals.law.harvard.edu/jlpp/interim-final-rules-and-the-apa-some-rule-of-law-problems-thomas-e-nielsen/.

Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2021. *Medicaid demonstrations and impacts on health coverage: A review of the evidence*. Washington, DC: ASPE. https://aspe.hhs.gov/reports/medicaid-demonstrations-impacts-health-coverage-review-evidence.

Singleton, S., and J. Wagner. 2026. Assessing the Medicaid work requirement vendor landscape. Washington, DC: Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/assessing-the-medicaid-work-requirement-vendor-landscape.

Sommers, B.D., L. Chen, R.J. Blendon, et al. 2020. Medicaid work requirements in Arkansas: Two-year impacts on coverage, employment, and affordability of care. *Health Affairs* 39, no. 9: 1522–1530. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.00538.

Sommers, B.D., M.R. Tomasi, K. Swartz, and A.M. Epstein. 2012. Reasons for the wide variation in Medicaid participation rates among states hold lessons for coverage expansion in 2014. *Health Affairs* 31, no. 5. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2011.0977.

U.S. Government Accountability Office (GAO). 2025. Medicaid demonstrations: Information on administrative spending for Georgia work requirements. Report no. GAO-25-108160. Washington, DC: GAO. https://www.gao.gov/assets/gao-25-108160.pdf.

U.S. Government Accountability Office (GAO). 2019. Medicaid demonstrations: Actions needed to address weaknesses in oversight of costs to administer work requirements. Report no. GAO-20-149. Washington, DC: GAO. https://www.gao.gov/assets/gao-20-149.pdf.

Zhang, E., and G. Lukens. 2025. Medicaid work requirements will take away coverage from millions: State and congressional district estimates. July 22, 2025. Washington, DC: Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/medicaid-work-requirements-will-take-away-coverage-from-millions-state-and.

APPENDIX 1A: Data Sources and Considerations for Identifying Mandatory Exceptions

TABLE 1A-1. Examples of Potential Data Sources and Relevant Considerations for Identifying Individuals Excluded from Community Engagement Requirements Cited by Interviewees

Excepted population group	Potential data sources	Considerations
Youth formerly in foster care	• Enrollment data	Identifying youth formerly in foster care could be challenging, particularly for individuals formerly in out-of-state foster care.
American Indians or Alaska Natives	• Enrollment data	None identified in our interviews with select stakeholders.
Parents, guardians, caretaker relatives, or family caregivers[1]	• Enrollment data • Claims or managed care encounter data	States could use enrollment data to identify beneficiaries with a dependent child younger than age 14 or with a disabled individual in their household. Also, states could identify recent births in claims or managed care data to identify parents or guardians with a dependent child. Some states noted that identifying caregivers in particular can be challenging, and clear CMS guidance could help address this issue.
Veterans with a total disability rating	• Data from state or local agency that governs veterans' affairs	Not all states exchange data with their veterans' affairs agencies, and therefore, they will need to develop processes for obtaining information on this population. In addition, the disability criteria used for veterans may not align with the criteria used by Medicaid. One state noted that because of these challenges, they will check eligibility for this exclusion only if a beneficiary does not meet the criteria for any other exclusion or exception.
Individuals who are medically frail or otherwise have special needs[2]	• Claims or managed care encounter data • Clinical data (e.g., medical record data from a health information exchange)	The criteria for individuals in this category are not well defined, and states' ability to identify them will be highly dependent on CMS guidance. Claims and managed care encounter data have limitations, including timeliness and reliability, that affect their use for identifying individuals in this group. Clinical data could serve as a timelier source of information compared to claims.

TABLE 1A-1. (continued)

Excepted population group	Potential data sources	Considerations
Individuals meeting TANF work requirements or receiving SNAP benefits and subject to SNAP work requirements	• Integrated eligibility system • Data from state or local TANF or SNAP agency	States with integrated eligibility systems, relative to those without, can more easily identify Medicaid beneficiaries compliant with SNAP or TANF work requirements. Stakeholders raised questions regarding the alignment, or lack thereof, between Medicaid CE requirements and those in SNAP or TANF, including the potential for beneficiaries to experience added burden if their compliance with Medicaid and SNAP requirements are assessed at different times.
Individuals participating in a drug addiction of alcohol treatment program	• Claims data • Data from behavioral health providers	Stakeholders noted data privacy concerns related to behavioral health data for obtaining the needed information to identify this population.
Individuals who are incarcerated	• Data from state and local correctional authorities	States may need to obtain additional data to identify individuals who are incarcerated. One state noted that they have a process for data exchange with state prisons but not with local jails.
Pregnant or postpartum women	• Enrollment data • Claims or managed care data • Self-attestation	Individuals eligible for Medicaid via a pregnancy-related pathway can be identified in enrollment data. Beneficiaries in the new adult group that become pregnant could be identified using claims or managed care data.

Notes: CMS is the Centers for Medicare & Medicaid Services. TANF is the Temporary Assistance for Needy Families Program. SNAP is the Supplemental Nutrition Assistance Program. CE is community engagement.

[1] Individuals in this category must be caregivers (as defined in § 2 of the RAISE Family Caregivers Act (P.L. 115-119)) of a dependent child age 13 years or younger or of a disabled individual.

[2] Individuals in this category could include individuals who are blind or disabled; with a substance use disorder; with a disabling mental disorder; with a physical, intellectual, or developmental disability that substantially impairs their ability to perform one or more activities of daily living; or with a serious or complex medical condition.

Source: MACPAC, 2025, analysis of state and stakeholder interviews conducted between June and August 2025.

Commission Vote on Recommendation

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendation included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendation. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on this recommendation on May 7, 2026.

Implementing Community Engagement Requirements in Medicaid

1.1 The Secretary of the U.S. 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 (CE) requirements in Medicaid. The monitoring plan should provide insight into how such policies affect eligibility and enrollment. CMS should identify new metrics for state reporting and build upon existing data collection to minimize administrative burden. The evaluation plan should outline, at a minimum, CMS's approach to evaluating the effect of CE requirements on employment, health, and state and federal administrative and program spending. CMS should ensure timely publication of monitoring and evaluation results to inform policy and operational decision making.

1.1 voting result	#	Commissioner
Yes	15	Allen, Bjork, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McFadden, Nardone, Snyder
No	2	Brown, McCarthy

Chapter 2:

Automation in Medicaid Prior Authorization

Automation in Medicaid Prior Authorization

Recommendations

2.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance to state Medicaid agencies and Medicaid managed care plans clarifying that, for determinations of medical necessity, the language at 42 CFR 438.210(b)(3) requires an individual with appropriate expertise to review and authorize all decisions to deny service authorizations or to authorize a service in an amount, duration, or scope that is less than requested, including those proposed by automated systems. This guidance should clarify further that (1) adverse determinations may not be made by automation tools alone; (2) adverse determinations must be made based on individualized determinations of medical necessity; (3) all existing regulatory requirements related to adverse determinations apply whether or not automation is used in the process of issuing an authorization decision.

2.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend the regulations at 42 CFR 440.230 to provide that, for determinations of medical necessity in fee-for-service Medicaid programs, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

2.3 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance to state Medicaid agencies and Medicaid managed care plans specifying ways in which existing regulatory oversight processes (42 CFR 438.66), including the external quality review process (42 CFR 438.350) and mandated plan reporting required for Managed Care Program Annual Reports (42 CFR 438.66(e)(1)), can be used to create effective oversight of managed care plans' use of automation in prior authorization.

2.4 State Medicaid agencies should amend their Medicaid managed care plan contracts, on a timeline that is practicable, to require disclosure or other reporting of the use of automation in plans' coverage and authorization processes described at 42 CFR 438.210. Disclosure should facilitate state visibility into the applications of automation tools and other meaningful elements of automation, such as plans' protocols for testing, evaluation, and oversight. To the extent possible, states should modify existing reporting requirements or existing oversight processes to minimize additional administrative burden.

Automation in Medicaid Prior Authorization

Key Points

- Prior authorization (PA) is the process by which health care payers require medical providers to request and receive approval before providing certain items, services, or medications. Medicaid fee-for-service programs and managed care plans use PA to promote appropriate, cost-effective care and reduce wasteful spending.
- States, managed care plans, and providers are using automation tools, such as artificial intelligence and rules-based algorithms, to streamline steps in the PA process. When used in Medicaid PA, automation can reduce administrative burdens, facilitate faster PA decisions, and support more appropriate and cost-effective care. However, stakeholders have raised concerns about risks, such as bias, incorrect denials, and reduced transparency.
- Some states and plans are using automation tools to approve PA requests without human review. Interviewed states and plans emphasized that their automation tools do not deny PA requests and that all denials must be reviewed by a human.
- Although federal regulations cover many aspects of Medicaid PA, none explicitly addresses the use of automation in Medicaid PA. Some states and managed care plans stated that they are reluctant to implement automation due to a lack of federal guidance. Some states have passed laws concerning the use of automation in PA, but variation in these laws can create confusion or compliance burdens for managed care plans and information technology vendors.
- The federal government and states have limited visibility into when and how managed care plans use automation in Medicaid PA and the impact of automation on costs and access to care. Existing federal and state oversight and monitoring mechanisms could be adapted to improve visibility into managed care plans' use of automation.
- MACPAC proposes three principles to guide the adoption, monitoring, and regulation of automation in Medicaid:
  - Automation in Medicaid PA offers administrative efficiencies for payers and providers, which can improve timeliness of approvals, beneficiary experience, and access to care.
  - Transparency and disclosure are important tools in documenting and assessing the use of automation, including the nature of emerging risks.
  - Due to the evolving nature of automation technologies and their increasing application, ongoing reevaluation of the oversight policy framework in Medicaid PA is warranted.

CHAPTER 2: Automation in Medicaid Prior Authorization

Rising health care spending has led payers, including Medicaid, to adopt strategies that seek to contain costs while preserving beneficiary access to appropriate care. In the U.S. health care system, estimates of wasteful spending range from $600 billion to more than $1.9 trillion per year (Speer et al. 2020). Public and private insurers employ utilization management (UM) strategies to minimize unnecessary spending. Prior authorization (PA) is a primary UM strategy.

PA is the multistep process by which health care payers require medical providers to request and receive approval before providing certain items, services, or medications (Pestaina and Pollitz 2022). Some studies have shown that PA can reduce health care costs without negatively impacting care quality; however, others have raised concerns that PA can harm patients (Asher et al. 2020, 2019). A recent U.S. Department of Health and Human Services Office of the Inspector General report found that Medicare Advantage (MA) plans incorrectly denied PA requests, which may have prevented or delayed MA beneficiaries from receiving medically necessary care (OIG 2022). Furthermore, surveys of health care providers show that PA occupies a substantial portion of staff time and that some providers employ full-time staff dedicated exclusively to PA (AMA 2024, Sahni et al. 2024).

Providers and health plans have begun to use automation tools in parts of the PA process, including submitting requests and making PA determinations (Mello 2026, Tripathi et al. 2024, UnitedHealth Group 2024). Automated systems that use algorithms or artificial intelligence (AI) to conduct portions of the PA process have the potential to reduce burdens associated with PA and promote appropriate, cost-effective care (UnitedHealth Group 2024, Diane et al. 2023, Dada et al. 2022). However, providers, beneficiary advocates, and other stakeholders argue that automation may lead to harms, such as increased adverse determination rates, bias leading to incorrect adverse determinations, and reduced transparency into PA determinations (Mello et al. 2026, Lubell 2025, Permanent Subcommittee on Investigations 2024, Center for Medicare Advocacy 2022).

The Commission conducted a study to understand the extent to which states, managed care plans, and providers are using automation in the Medicaid PA process and to identify potential policy levers to oversee its use. MACPAC conducted a review of state and federal policies concerning automation; a literature review on the use of automation in PA; and interviews with stakeholders representing states, managed care plans, information technology (IT) vendors, providers, and beneficiaries. In this research, our definition of automation tools included both AI and rules-based algorithms, and we focused on the PA determination process; we did not examine the use of automation to define clinical PA criteria or the use of automation in the PA appeal process or in other elements of payers' UM systems. Where our findings examine the use of automation in the authorization decision itself, our work focused on clinical determinations of medical necessity for covered benefits.[1]

Through this work, MACPAC found that states and managed care plans deploy AI and algorithms to conduct a wide variety of functions in the Medicaid PA process. This research also identified challenges related to automation in Medicaid PA: there is limited transparency into how automation is being used and its impacts on beneficiaries and the program, and there is limited federal guidance on how states and managed care plans may use automation in the Medicaid PA process.

To address these challenges, the Commission makes four recommendations to clarify oversight of PA determinations made by automated PA systems and to promote transparency into automation's use and impacts in Medicaid PA:

2.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance to state Medicaid agencies and Medicaid managed care plans clarifying that, for determinations of medical necessity, the language at 42 CFR 438.210(b)(3) requires an individual with appropriate expertise to review and authorize all decisions to deny service authorizations or

to authorize a service in an amount, duration, or scope that is less than requested, including those proposed by automated systems. This guidance should clarify further that (1) adverse determinations may not be made by automation tools alone; (2) adverse determinations must be made based on individualized determinations of medical necessity; (3) all existing regulatory requirements related to adverse determinations apply whether or not automation is used in the process of issuing an authorization decision.

2.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend the regulations at 42 CFR 440.230 to provide that, for determinations of medical necessity in fee-for-service Medicaid programs, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

2.3 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance to state Medicaid agencies and Medicaid managed care plans specifying ways in which existing regulatory oversight processes (42 CFR 438.66), including the external quality review process (42 CFR 438.350) and mandated plan reporting required for Managed Care Program Annual Reports (42 CFR 438.66(e)(1)), can be used to create effective oversight of managed care plans' use of automation in prior authorization.

2.4 State Medicaid agencies should amend their Medicaid managed care plan contracts, on a timeline that is practicable, to require disclosure or other reporting of the use of automation in plans' coverage and authorization processes described at 42 CFR 438.210. Disclosure should facilitate state visibility into the applications of automation tools and other meaningful elements of automation, such as plans' protocols for testing, evaluation, and oversight. To the extent possible, states should modify existing reporting requirements or existing oversight processes to minimize additional administrative burden.

This chapter begins with a background on PA in Medicaid, automation in PA, and state and federal policy concerning automation in PA. It then describes how states, managed care plans, and IT vendors are using and governing automation in the Medicaid PA process. Next, the chapter describes challenges presented by the use of automation in the Medicaid PA process. It also presents the Commission's recommendations and associated rationale as well as implications for federal spending, states, enrollees, plans, and providers. The chapter concludes with a summary of findings and considerations.

Background

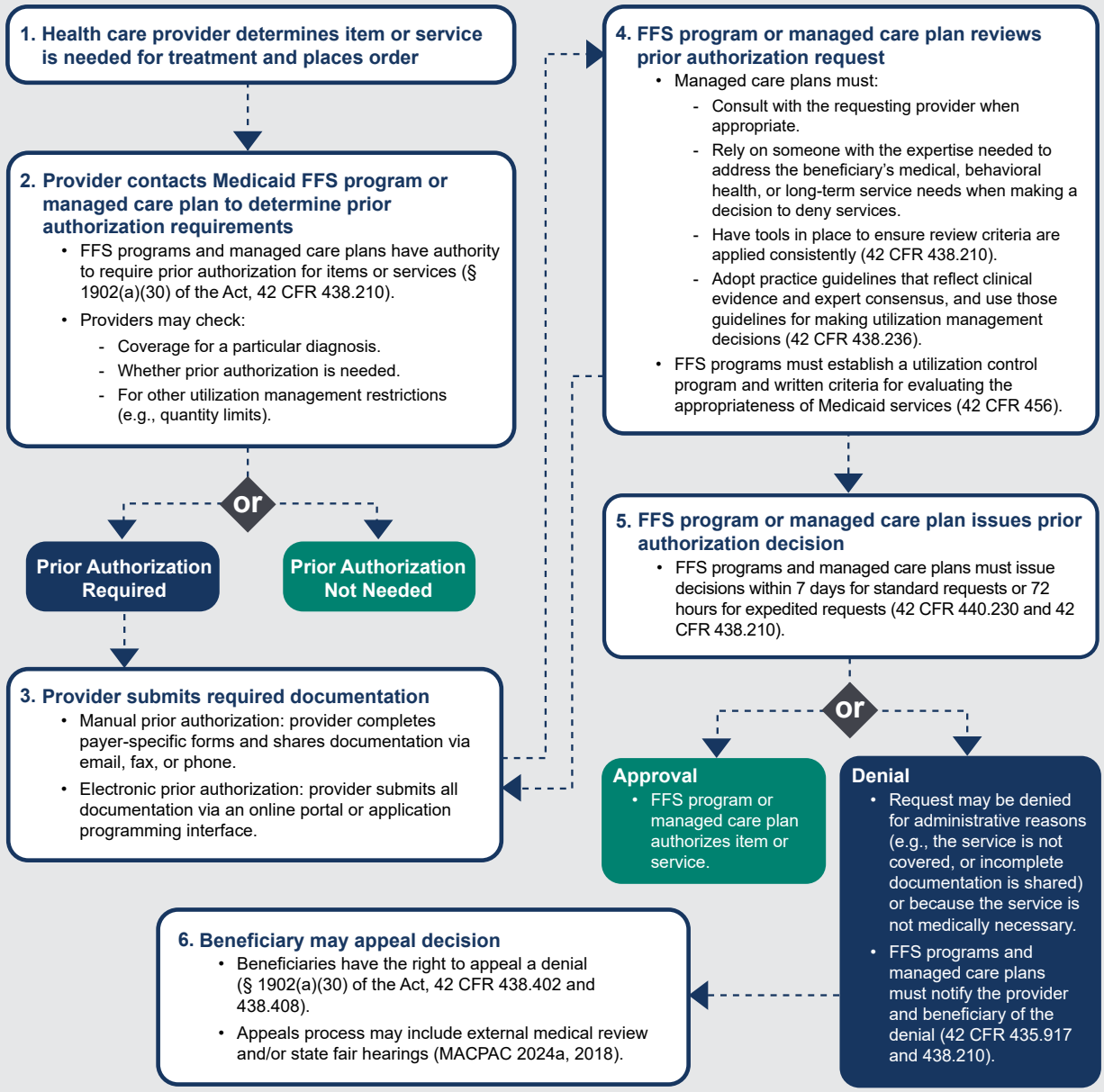
Medicaid PA

Medicaid statute and regulations provide states the authority to implement UM to safeguard against unnecessary utilization and ensure the efficiency, quality, and economy of care (§ 1902(a)(30) of the Social Security Act (the Act), 42 CFR 440.230). Likewise, federal regulations require state managed care contracts to permit managed care plans to use UM processes such as PA. State Medicaid agencies and managed care plans have flexibility to determine what services and medications require PA, with some limitations (§ 1902(a)(30) of the Act, 42 CFR 438.210). For example, Medicaid payers cannot impose PA requirements for any screening services provided under the early and periodic screening, diagnostic, and treatment benefit (CMS 2014).

In a typical PA process (Figure 2-1), health care providers submit clinical and administrative information to a payer, which reviews and issues a PA decision (Pestaina and Pollitz 2022). In straightforward cases, the provider submits documentation to demonstrate the necessity of the care, the payer reviews and approves the PA request, and the service or item is provided to the patient. In cases in which the request is not approved, the payer may request additional documentation, partially deny the request (e.g., approving less than what was requested), or deny

the request outright. Payers may deny PA requests because the plan does not cover the requested services, the provider is out of network, or the request is incomplete (often referred to as administrative denials) or because the request does not meet the plan's medical necessity criteria. Partial or full denials are commonly called adverse decisions or adverse determinations.[2]

FIGURE 2-1. Medicaid Prior Authorization Process for Medical Services and Items



Notes: FFS is fee for service. The Act is the Social Security Act. This process diagram does not apply to prescription drugs.

Source: Adapted in 2026 from MACPAC 2024.

The services and medications that require PA can vary among state Medicaid programs and plans. Medicaid services that commonly require PA include non-emergency medical transportation, durable medical equipment (DME), behavioral health services, inpatient hospital stays, inpatient and outpatient surgeries and procedures, rehabilitation services, long-term services and supports (LTSS), and prescription drugs (KFF 2018).

Regulation of Medicaid PA

Federal regulations guide how Medicaid fee-for-service (FFS) programs and managed care plans can implement PA. For example, payers must make PA decisions within a certain time frame and expedite requests if beneficiaries need urgent medical care. Federal regulations also prohibit payers from arbitrarily denying a service based on a beneficiary's diagnosis or illness type (42 CFR 440.230, 438.210). States can impose additional PA restrictions on managed care plans, such as imposing shorter decision time frames and prohibiting PA for certain items, services, or medications (42 CFR 438.210).

In 2024, the Centers for Medicare & Medicaid Services (CMS) issued its Advancing Interoperability and Improving Prior Authorization Processes final rule (CMS-0057, the interoperability rule), which introduced new requirements impacting key aspects of PA (CMS 2024a). The new requirements include: (1) shorter time frames for PA decisions in Medicaid managed care (7 days instead of 14), (2) that payers inform providers of the specific reasons for adverse decisions, (3) public reporting of PA metrics, and (4) implementation of new PA application programming interfaces. The new application programming interfaces (APIs)[3] will help with information sharing among payers, providers, and patients to reduce administrative burden and promote continuity of care and transparency. The rule introduces decision time frames and reporting requirements to Medicaid FFS, which have not been subject to such requirements in the past. These provisions take effect in 2026 and 2027 and apply to State Children's Health Insurance Program (CHIP) payers (FFS and managed care), MA plans, and Qualified Health Plans (CMS 2024a). This rule does not apply to prescription drugs; however, the 2026 CMS Interoperability Standards and Prior Authorization for Drugs Proposed Rule would extend many of these requirements to PA for prescription drugs (CMS 2026, 2024a).

Oversight of Medicaid PA

Medicaid UM, including PA, is subject to federal and state oversight. Though states have the flexibility in how they implement PA, CMS can exercise its oversight authority to audit, correct, or disapprove state practices not in compliance with federal statute or regulations (42 CFR 430). Federal regulations impose requirements on state managed care contracts, including PA policies and procedures, decision time frames, and notices (42 CFR 438.210). CMS reviews and approves state managed care contracts and, through its review, can assess contractual compliance with the standards set forth in regulation (42 CFR 438.3).

State Medicaid agencies oversee their managed care plans' compliance with contractual requirements, including those related to PA (42 CFR 438.66). States must contract with external quality review organizations (EQROs) to conduct regular reviews of their managed care plans' performance, including plans' compliance with UM and PA requirements (42 CFR 438.350–438.370). Although the EQRO review guidance does not require collection of specific data elements related to UM and does not require that EQROs assess whether PA denials are clinically appropriate, CMS includes optional guidance for interviewing UM staff and assessing policies and procedures (CMS 2023).

Additionally, Section 1932(b)(4) of the Act requires managed care plans to have an internal system for beneficiaries to challenge denials of care resulting from PA. Federal regulations specify the processes and timelines related to denials and appeals and allow states to modify certain aspects of the process (e.g., shorter time frames and external medical review) (42 CFR 438.210).

Automation

MACPAC defines automation as the use of technological tools such as algorithms and AI that supplement or replace human action or decision making. This definition of automation does not include IT tools that automate or validate information transmission, such as APIs. There are important distinctions between different types of automation technologies, such as algorithms and AI, that are relevant to PA practices in Medicaid. The following definitions apply throughout this chapter (Box 2-1).

Automation in PA

Payers and providers can use automation in nearly all steps of the PA process. For example, providers can use automation tools to prefill forms, check compliance with policies, predict decisions at the point of care, and retrieve documents for PA appeals (Mello 2026). Payers can use automation to convert improperly formatted PA requests into an interoperable format, reducing decision time frames (Tripathi et al. 2024). Payers also can use automation to make PA decisions (UnitedHealth Group 2024). According to publicly available information, most health plans do not allow automated PA systems to issue adverse decisions and instead allow them to approve PA requests or refer requests to a human reviewer who issues adverse decisions when appropriate (Miller et al. 2024). Such configurations are often referred to as "human-in-the-loop" policies.

These applications present many potential benefits, including reduced administrative burdens, faster decision time frames, and more appropriate and cost-effective care for beneficiaries. For example, one case study found that generative AI reduced the time required to draft a PA request letter for orthopedic surgery from 1 to 2 hours to 10 minutes (Diane et al. 2023). IT vendors have reported up to a tenfold increase in the speed of PA submissions after switching to automated processes, with a median approval time of 29 seconds in some cases (UnitedHealth Group 2024). Finally, some research has found that automation tools can make PA decisions that result in more appropriate, cost-effective care. For example, one study applied a rules-based algorithm to identify cases in which patients could be shifted to lower-cost services without reducing quality of care (Dada et al. 2022).

BOX 2-1. Definitions

Algorithm: A procedure or set of rules that is applied to a dataset to achieve a certain function or purpose. In the context of artificial intelligence (AI), an algorithm is the logic by which an AI model operates (IBM 2024). In the context of prior authorization, CMS defines algorithms as a decisional flow chart of a series of if-then statements that leads to a given output (e.g., if the patient has a certain diagnosis, they should be able to receive a test) (CMS 2024).

Artificial intelligence (AI): A machine-based system that can, for a given set of human-defined objectives, make predictions, recommendations, or decisions influencing real or virtual environments. AI systems use machine- and human-based inputs to perceive real and virtual environments; abstract such perceptions into models through analysis in an automated manner; and use model interface to formulate options for information or action (CMS 2024).

Generative AI: AI models that draw from large swaths of existing data to create complex original content such as long-form text, high-quality images, or realistic videos or audio (IBM 2024b). The data that generative AI models draw from may include large-language models which use technology to learn from unstructured, free-text data to improve the validity and quality of generated data (Toner 2023).

Predictive AI: AI models that draw from targeted historical data to find patterns and forecast future outcomes about the most likely upcoming event, result, or trend (IBM 2024c).

However, automated PA systems present potential risks, such as increased denial rates, bias, and reduced transparency. For example, the U.S. Senate Permanent Subcommittee on Investigations found that implementation of automation initiatives in at least one MA plan's PA process coincided with increased rates of denials for post-acute care (10.9 percent in 2020 to 22.7 percent in 2022) (Permanent Subcommittee on Investigations 2024). AI-based automation tools may be biased if they are trained on data that are not representative of the population they encounter in production and may make incorrect decisions if social determinants of health are not represented in patient data (Mello et al. 2026). Automation may also reduce transparency into the PA decision making process because of the complexity of advanced AI-based tools and because IT vendors and health plans may hold exclusive rights to automation tools (Center for Medicare Advocacy 2022). Finally, risks may persist under human-in-the-loop policies if human reviewers do not conduct thorough reviews or if requests are presented in a manner that biases reviewers toward agreeing with automated decisions (Mello et al. 2026).

Regulation, guidance, and oversight of automation

Existing Medicaid statutes and regulation do not explicitly contemplate or address the use of automation tools in Medicaid PA. Medicaid managed care regulations require that PA decisions be made by an individual with the "appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs" (42 CFR 438.210(b)(3)). Though the use of the word "individual" implies that a human must be involved, this regulation does not explicitly bar automation tools from issuing adverse decisions. In response to public comment on the interoperability rule, CMS acknowledged the possibility of automation in authorization decisions but has not changed regulatory language to date (CMS 2024a). There is no equivalent regulatory provision requiring that an individual with expertise review PA decisions made in Medicaid FFS. Additionally, there is no federal requirement obligating states to collect information from managed care plans about if and how they use automation in Medicaid PA.

Outside of the Medicaid program, CMS has issued guidance regarding PA automation in MA plans. A "Frequently Asked Questions" guidance document issued following the 2024 Medicare Parts C and D final rule provided guidance regarding how and when algorithms or software tools may be used in PA (CMS 2024b). The guidance states that although MA plans can use AI or algorithms to assist with PA decisions, automation must not replace patient-specific evaluations to ensure equitable and accurate application of coverage criteria. It states that automation tools cannot deny coverage based solely on predictions and that decisions must be based on the "individual patient's medical history, the physician's recommendations, or clinical notes." The guidance also states that AI cannot be used to shift the coverage criteria over time or apply other internal coverage criteria that are not otherwise publicly available. CMS recommends that MA organizations should ensure the tools do not perpetuate or exacerbate existing biases or introduce new biases in accordance with non-discrimination requirements in Section 1557 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) (CMS 2024b).

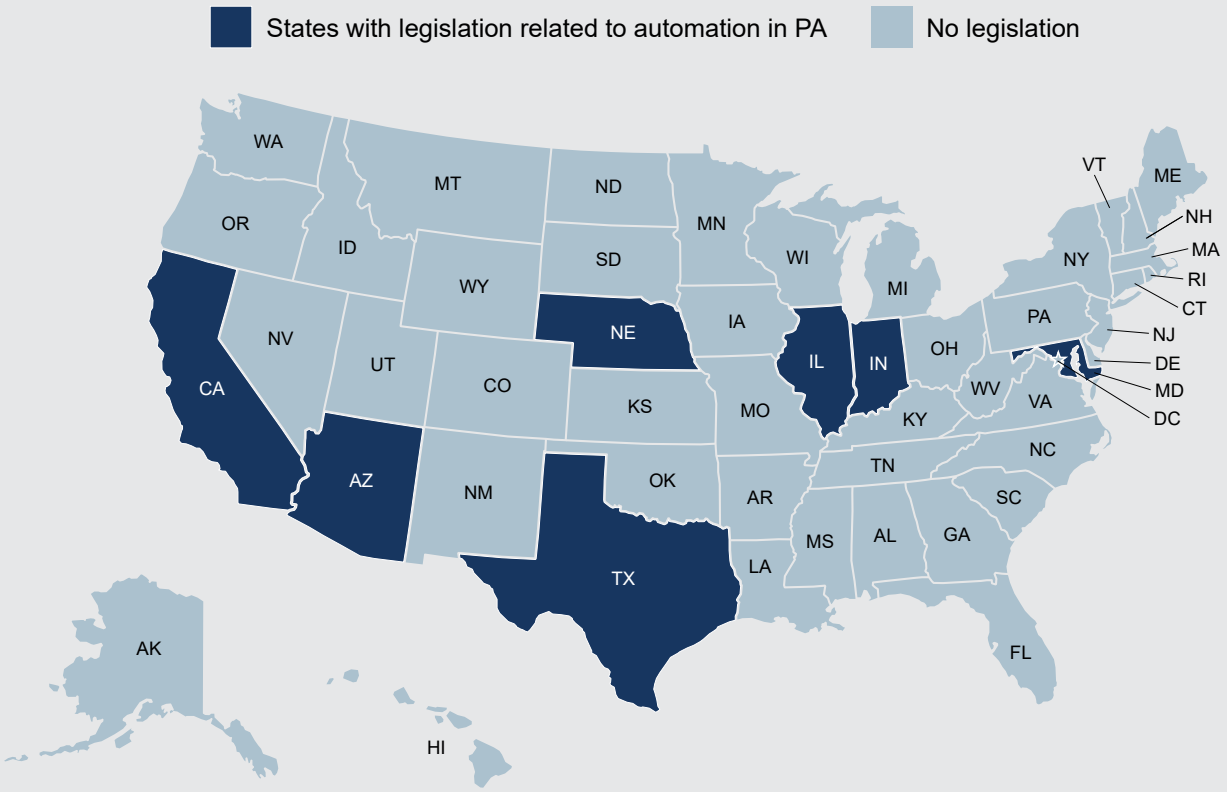
The legislative and executive branches have not acted to legislate or regulate automation in PA. Congress has shown interest in automation generally and in health care specifically but has not taken legislative action to date (Bipartisan House Task Force on Artificial Intelligence 2024, Chu et al. 2024, Committee on Finance 2023). The Trump Administration's AI strategy has focused on reducing regulatory burdens for AI development and applications and has identified state AI regulations as a barrier to innovation. The Administration issued an executive order directing the Secretary of Commerce and Attorney General to identify and take action against onerous state AI regulations, and the Administration has called on Congress to preempt state AI laws (White House 2026, Executive Office of the President 2025).

As of December 2025, seven states had passed laws to regulate the use of automation in PA under their authority to regulate commercial health plans (Figure 2-2 and Table 2B-1). These laws do not define automation uniformly: some states (California, Illinois, Texas) include both AI and rules-based algorithms in their definitions, while other states (Arizona, Maryland,

Nebraska) include only AI-based tools. Six of the seven states (Arizona, California, Illinois, Maryland, Nebraska, and Texas) passed laws requiring that a human review all adverse decisions issued by health plans. Some state laws include additional measures to protect beneficiaries. For example, California and Maryland require automation tools to base decisions on patients' individual clinical information, bar payers from making PA decisions based solely on group data, and prohibit payers from using automation to discriminate against protected classes. State laws also take a varying approach to transparency. California, Maryland, Nebraska, and Texas require UM entities to make automation tools available for audit by request. Only two state laws have public disclosure requirements: Nebraska requires utilization review entities to publicly disclose if they use AI for PA decisions, and Indiana requires plans to publish their PA requirements and approval and denial statistics.

The National Association of Insurance Commissioners developed a model bulletin addressing the use of AI in insurance, which has been adopted by 25 states, and is currently piloting an AI evaluation tool for use by state regulators to identify uses and vulnerabilities in AI use by insurers, including PA (NAIC n.d., NAIC 2023).

FIGURE 2-2. States with Legislation Related to Automation in Prior Authorization



Note: PA is prior authorization.

Source: MACPAC and Mathematica, 2025 federal and state policy review.

Current Use and Oversight of Automation in Medicaid PA

In our interviews, all states and managed care respondents reported using automation tools, most often rules-based algorithms that use clinical criteria to determine medical necessity. Stakeholders stated that some forms of automation have been in use much longer, particularly programmed algorithms or programs that categorize and route inbound electronic PA requests for approval or review. Interviewees reported using automation more frequently for certain services, such as imaging services, DME, dental services, and pharmaceuticals.

The PA process can be lengthy and complex. Figure 2-3 shows the typical steps required for PA in Medicaid programs (as shown in Figure 2-1) and the types of automation that may be employed to address them. Appendix 2A includes a complete table (Table 2A-1) of uses of automation throughout the Medicaid PA process, including challenges cited by the literature and our interviewees.

FIGURE 2-3. Medicaid Prior Authorization Process and Potential Automation Use Cases

Notes: PA is prior authorization. AI is artificial intelligence. FFS is fee for service. NLP is natural language processing.

Source: Mathematica and MACPAC, 2025 literature review and interviews.

States and providers reported using automation to synthesize and analyze large amounts of information and to extract information from sources such as policy manuals, electronic health records, clinical notes, and PA requests. One state reported using an AI tool that allows caseworkers to query a long-term care coverage manual via chatbot, simplifying the process for assessing coverage and authorization policies. States reported using generative AI systems to promote administrative efficiency in the PA review process. Examples include tools that convert unstructured data from submitted requests into structured data for review, summarize clinical reviewers' notes when responding to appeals, convert faxed PA submissions into searchable documents, or detect potentially fraudulent requests. Providers reported using automation for similar administrative-efficiency applications, such as transferring unstructured clinical data into authorization requests, and thus, their use may not be exclusive to Medicaid programs or populations.

A subset of stakeholders reported using automation tools to make PA decisions. These stakeholders consistently reported that their automation tools do not issue adverse decisions and only approve requests or refer them for clinician review. They stressed that their PA systems still rely exclusively on human review for adverse determinations. One state reported its system will issue automated denials for administrative reasons (e.g., when a PA is not required for a service or the request is incomplete), but noted that the system will notify the submitting provider of the reason for denial and will direct them to resubmit in these cases. Stakeholders described automation as a technology used primarily to expedite approvals and route requests to individuals with the best expertise for a given request (e.g., a pharmacist for a prescription PA). Stakeholders also stated that automation can approve simpler requests and leave reviewers more time to focus on complex PAs.

Despite the wide range of applications reported, AI use in PA remains in the early stages. For example, states and IT vendors reported a more limited use of AI-based tools in FFS programs than in managed care. Similarly, some stakeholders stated that smaller (often rural) systems face financial and workforce barriers to adopting automation. This dynamic may result in an uneven distribution of automation's potential benefits, with less-resourced systems not fully realizing its efficiencies or benefits. However, stakeholders in all groups expect the use of automation tools in PA to expand in the future as states use automation to reduce spending on program administration and oversight and exchange knowledge from their implementations.

Automation oversight structures

Some state Medicaid agencies have implemented governance structures, such as oversight boards and ethics frameworks, to monitor and guide the use of automation tools in their states' programs. Medicaid programs have long used algorithms, particularly within clinical decision making. With increasing adoption of AI, stakeholders reported an increase in interest in AI governance boards or groups, and multiple states reported implementing such structures to monitor and guide the use of AI in their Medicaid programs. These groups typically review proposed applications of AI in their states' Medicaid programs and address concerns related to beneficiary impact, human oversight, and data privacy. Other states reported they do not have formal governance structures and delegate oversight roles to existing Medicaid offices or larger governance bodies. For example, one state uses its Medicaid Transformation Management Office to vet automation projects for compliance, fiscal impacts, and potential risks.

Interviewees did not identify any formal state oversight and monitoring structures specific to automation in Medicaid PA. State Medicaid agencies reported they have access to PA data through existing compliance activities and reporting metrics (e.g., percentage of PA requests resulting in a partial or full denial). However, interviewees reported that states may detect automation only if it results in a noticeable change in these metrics. Some states mentioned plans to implement new PA timeliness reporting requirements that may enable this, but no respondents reported developing metrics specific to assessing the performance of automated PA tools. Some states reported that they lack time and resources to develop

oversight and monitoring mechanisms for automation in PA. Interviewees stated that it is difficult for some states to develop oversight policies on their own, and that states typically look to the federal government for guidance to develop oversight mechanisms.

Some managed care plans, providers, and IT vendors have established governance structures and ethics frameworks. For example, one plan published a Statement of AI Principles, which outlines the health plan's requirements for accountable and compliant use of AI, including the requirement that clinician reviewers retain decision making authority for any adverse decisions. The American Medical Association advocates for legislative and regulatory action that increases oversight of AI in PA, including measures to increase transparency and ensure clinician review of PA requests (AMA 2025). Some IT vendors have taken a similar approach, with one framework describing best practices such as model validation and monitoring to reduce bias and reviews by clinicians to ensure fair and accurate determinations. Additionally, a group of private and public sector stakeholders has created the Coalition for Health AI, which focuses on AI in health care broadly. The coalition has published best practices for health care professionals developing, implementing, or using AI and has convened an AI-supported PA systems workgroup (CHAI 2026). Additionally, the National Health Law Program, an organization that has advocated on behalf of Medicaid beneficiaries, has released a list of principles for automated decision making systems (i.e., AI and algorithms) in public benefits such as Medicaid. One principle asserts that government agencies must ensure due process for all benefits-related decisions (Machledt and Edwards 2023).

Private and public sector governance structures are subject to limitations. Effective governance requires automation subject matter expertise and resources, which some states and health systems may lack. Stakeholders stated that smaller health systems may not have the resources and expertise to implement effective oversight structures, potentially exposing their patients to greater risk. Additionally, state governance bodies that are not legislatively mandated may have limited resources, may rely on oversight mechanisms that predate the adoption of automation in the PA process, and may not be suited for automation governance. Private sector governance structures are voluntary and self-regulated: health plans and vendors can choose whether to establish or participate in governance structures and can write their own rules, which may limit their effectiveness. Finally, information on governance structures was not broadly available as part of our policy scan and literature review; as such, it is difficult to know the breadth or effectiveness of such approaches.

Challenges with Automation in PA

The findings from our literature review, policy scan, and interviews revealed challenges posed by automation in Medicaid PA, including limited transparency and inconsistent federal guidance.

Limited transparency

Stakeholders representing beneficiaries and providers raised concerns about transparency in interviews. They stated that they have little visibility into how and when automation is being used, how automation tools make PA decisions, and the approval and denial rates for automated systems. Absent this information, it is difficult to determine whether automated systems are making fair PA decisions or impacting beneficiaries' access to care. Beneficiary advocates stated that payers and UM entities often cited intellectual property protections to prevent advocates from examining automation tools. Advocates raised similar concerns in literature, noting that IT developers hold exclusive rights over the automation tools they develop, which can limit transparency into how these tools function (Center for Medicare Advocacy 2022).

The nature of AI itself also presents barriers to transparency. Modern AI systems are complex, employing hundreds or even thousands of layers of analysis to produce outputs. Stakeholders stated that the complicated nature of AI limits understanding of how and why PA decisions are made. One beneficiary

advocate warned that there is little information on whether AI tools are correctly applying care criteria beyond the outcomes themselves. Separately, a state representative noted that AI is not auditable in the same way as traditional PA because of its black box nature.

States can use their existing contracting and oversight authority to identify when and how managed care plans use automation in PA, but our evidence suggests such practices are not widespread. There is no federal requirement obligating states to collect information from managed care plans about if and how they use automation in Medicaid PA. States may leverage their existing contracts and oversight activities for managed care plans to identify adoption of automation, but it is unclear from our research how many choose to do so. Interviewees acknowledged that automation may be disclosed only voluntarily or on an ad hoc basis, or it may be detectable by the state when it results in a considerable or noticeable change in PA outcomes as they are tracked over time. CMS and states have existing oversight mechanisms, such as external quality review (EQR), Managed Care Program Annual Reports (MCPARs), and state contracting authority, that may provide insight into automation use. However, MCPAR does not require states to collect data on the use of automation in PA determinations. No respondents in our interviews reported using these mechanisms to conduct routine oversight of health plans' use of automation. Federal stakeholders stated that CMS could collect more data on automation in Medicaid PA by adding new reporting requirements to MCPAR, potentially aligned with implementation of the interoperability rule.

Limited transparency into automation systems also prevents states and the federal government from monitoring technical issues that impact PA decisions, such as data bias or programming flaws. An AI-based system can produce biased outputs if it is trained on data that are not representative of the population it will encounter in production. This is known as sample bias and is an inherent risk in AI (Jones 2019). Research has shown that sample bias can lead to skewed outputs in clinical AI tools. For example, AI models are more likely to misdiagnose illnesses among Medicaid beneficiaries and individuals of racial minority groups when they are not trained on data that represent these populations (Chen et al. 2023).

In interviews, stakeholders warned that this type of bias may produce incorrect adverse determinations for Medicaid beneficiaries. A provider representative stressed the importance of AI tools being trained on appropriate data and warned that commercial data do not reflect the complex patient population and services covered by Medicaid. Separately, a state representative noted that Medicaid beneficiaries may have less of a "digital footprint," such as electronic health records, than the general population, which may limit the availability of appropriate data.

Other programming errors can produce inaccurate PA decisions in complex AI-based systems and simpler algorithms. For example, one beneficiary advocate reported they discovered that a state's PA algorithm had a critical coding error that led to denials of care for large numbers of beneficiaries.

There are no data on the impact of these risks on adverse determination rates in Medicaid, but evidence from other insurance programs shows that automation may increase adverse determination rates. No studies to date have compared rates of denials or wrongful denials with and without automation (Mello et al. 2026).

Inconsistent federal guidance

Federal and state policy govern Medicaid managed care and FFS PA operations, such as timeliness, approval processes, and state oversight of managed care plan operations. However, adoption of automation in PA has rapidly evolved in recent years, and these policies do not directly regulate, guide, or monitor its use in PA. Currently, there are no requirements in statute or regulation that specifically address the use of automation in either Medicaid managed care or FFS PA. Language in federal Medicaid managed care regulations requires clinical oversight of adverse decisions, similar to the MA program; however, this language is silent on automation specifically. FFS PA regulations lack the same requirement for expert review of all adverse PA determinations.

Stakeholders reported that the absence of federal guidance makes many states and managed care plans reluctant to implement automation tools, especially in outward-facing applications like PA. One managed care plan stated that the lack of guidance and regulation specific to AI contrasts with the extensive guidance that CMS and other regulators have issued on topics such as data security, storage, and transmission. Stakeholders reported that some plans and states are reluctant to implement automation systems that may be superseded by federal action in the future, requiring costly reworks. One IT vendor noted there are no clear requirements for AI safety or testing. Other stakeholders reported they are wary of any public relations risk in implementing automation tools in the absence of guidance on these topics. States and Medicaid managed care plans have sought guidance from CMS about existing regulatory frameworks and permissible uses of automation in PA. CMS has acknowledged there is no Medicaid-specific guidance but points to other guidance, such as Medicare guidance, as a resource.

By contrast, states have introduced varying policies governing automation in PA and other areas. These policies vary across states both in how they define automation and in how they regulate it. For example, California and Maryland bar payers and UM entities from using automation tools to discriminate against protected classes. Stakeholders described navigating varying state laws and regulations and warned that variation creates additional compliance burdens for IT vendors, health plans, and UM entities implementing automation. For example, one MCO representative described review and approval processes for new IT, including automation tools, that vary from state to state and require substantial time and resources to navigate. A provider representative shared similar concerns, warning that variation in state approaches could create a fragmented regulatory environment that is difficult for providers and payers to navigate.

Many stakeholders spoke in support of federal action on automation in Medicaid PA, though some expressed reservations. State representatives supported federal regulations, guidance, and technical assistance. For example, one proposed the federal government set a floor of regulations that the states can build on. Multiple states supported CMS issuing guidance on PA automation oversight to help improve their own oversight practices. Managed care plans, providers, and vendors also expressed a need for regularly updated, standardized rules and guidance for testing, implementation, and safety that apply across states and patient populations. Furthermore, interviewees across stakeholder groups noted the importance of distinguishing between rules-based algorithms and machine-learning AI systems and warned that inconsistent definitions may lead to overregulating basic tools (such as clinical algorithms) or underregulating higher-risk AI models. However, provider and beneficiary advocates supported a broad definition of AI that includes rules-based algorithms, arguing that a narrow definition of AI may lead policymakers to overlook risks posed by rules-based algorithms.

Some states and managed care plans expressed reservations about federal regulation of automation in PA. A representative from a state with an existing AI oversight and governance approach expressed concern that federal action may require the state to rework its current approach to automation. Another state representative warned against the federal government taking a one-size-fits-all approach to automation that does not account for variation in states' size, resources, and Medicaid policies. State representatives also raised concerns about the additional compliance burden associated with new federal regulations, with one stating that implementation of the interoperability rule has already strained budgets and staff capacity. A managed care plan representative stated that federal regulations may limit its ability to pursue innovations that can shorten approval times, arguing that they may struggle to meet PA turnaround requirements without advancements in automation.

Principles for Automation in Medicaid PA

MACPAC proposes three principles to guide the adoption, monitoring, and regulation of automation in Medicaid PA. These principles reflect findings from MACPAC's research and highlight the views of the Commission.

Automation in Medicaid PA offers administrative efficiencies for payers and providers, which can improve timeliness of approvals, beneficiary experience, and access to care.

Evidence from the literature review and stakeholder interviews identified areas in which automation can introduce efficiencies to the PA process. This reduces burdens for providers, reduces PA decision time frames, and produces more appropriate and cost-effective care (UnitedHealth Group 2024, Diane et al. 2023, Dada et al. 2022). In interviews, states and managed care plans reported using automation to synthesize large volumes of information, extracting data from electronic health records, and to issue authorization approvals. Additionally, providers reported that they use automation to expedite the submission of PA requests and appeals.

However, literature and stakeholder interviews identified potential risks posed by automation: automation tools may produce incorrect adverse determinations and reduce transparency into PA processes (Mello et al. 2026, Center for Medicare Advocacy 2022). Policy targeting automation in Medicaid PA should carefully balance these potential risks and benefits to ensure that automated PA processes are used to provide Medicaid beneficiaries with timely, cost-effective, and clinically appropriate care.

Transparency and disclosure are important tools in documenting and assessing the use of automation, including the nature of emerging risks.

Stakeholder interviews revealed that although managed care plans, and to a lesser extent, states, are widely implementing automation tools, much is unknown about how they are being implemented and used and their impact on costs and access to care. Transparency into automation's use and impacts can reduce these unknowns and allow states and the federal government to better monitor potential risks (such as data bias and faulty programming). Disclosure and reporting requirements may offer states and other stakeholders the necessary transparency to help mitigate such risks. Policies addressing automation in Medicaid PA should reduce barriers to data and information about automation systems and encourage the collection of useful data about automation's development, implementation, and impacts. These policies should balance the need for this information while preserving opportunity for innovation in the field.

Due to the evolving nature of automation technologies and their increasing application, ongoing reevaluation of the oversight policy framework in Medicaid PA is warranted.

Automation technology is improving in its functionality and quickly expanding in domains such as health care. For example, the number of AI medical devices approved by the Food and Drug Administration increased twelvefold between 2018 and 2023 (Maslej et al. 2025). In interviews, stakeholders predicted that the use of automation in Medicaid PA will expand as well. One stakeholder claimed that AI may improve to the point that it provides faster and more accurate PA decisions than human clinicians. Given this rapid evolution in capabilities and applications, some of the risks identified by stakeholders may fade, while new risks may emerge in their place as automation use and application continues to grow. The federal policy framework addressing automation in Medicaid PA should be regularly reevaluated, using applicable available data, to minimize obstacles to technological innovation while remaining responsive to emerging risks.

Commission Recommendations

The following recommendations seek to address the challenges and findings identified by this research. The first pair of recommendations addresses the risks posed by automation tools and aims to strengthen oversight of adverse determinations of medical necessity for covered benefits. The second pair seeks to increase disclosure and transparency of managed care plans' use of automation in PA. Both

address the lack of federal guidance on automation by recommending federal action.

Clarifying oversight over adverse decisions

This project found that automation may pose risks to beneficiaries and providers through the way automated systems are used in adverse authorization determinations. Stakeholders reported that clinical and human oversight of PA processes can serve as a safeguard against this risk. However, there is limited federal guidance regarding automation in PA generally, and the existing policy framework does not clearly articulate federal minimum standards for direct oversight of PA automation. The following recommendations seek to address these challenges.

Recommendation 2.1

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance to state Medicaid agencies and Medicaid managed care plans clarifying that, for determinations of medical necessity, the language at 42 CFR 438.210(b)(3) requires an individual with appropriate expertise to review and authorize all decisions to deny service authorizations or to authorize a service in an amount, duration, or scope that is less than requested, including those proposed by automated systems. This guidance should clarify further that (1) adverse determinations may not be made by automation tools alone; (2) adverse determinations must be made based on individualized determinations of medical necessity; (3) all existing regulatory requirements related to adverse determinations apply whether or not automation is used in the process of issuing an authorization decision.

Rationale

Currently, regulations require "that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs" (42 CFR 438.210(b)(3)). This text does not offer clear direction on how automation may or may not be used in PA decisions. The requirement that decisions be made by "an individual" suggests that all adverse determinations must be made by humans; it does not explicitly state that automated systems cannot make adverse determinations, nor does it state if automation tools may approve PA requests. Furthermore, stakeholders did not identify this regulation as clear federal guidance on the use of automation in PA.

CMS should issue guidance clarifying that the regulatory text requires (1) an individual with applicable expertise must authorize all denials or partial denials; (2) that denials or partial denials must be made consistent with enrollee-specific medical, behavioral, or LTSS needs, which cannot be predicted through population-based models alone; and (3) that automated tools alone cannot authorize denials or partial denials. The guidance could clarify that automation tools may be used to review, route, and approve PA requests and aid decision making by human reviewers. Guidance could also clarify how federal regulatory requirements for Medicaid managed care plans apply to the issuance of notices when automation is used (42 CFR 438.404, 438.210). These regulations require that managed care plans inform beneficiaries of the reason for adverse determinations and make available upon request information such as medical necessity criteria and processes for setting coverage limits.

This recommendation addresses the risks that automation tools make incorrect adverse determinations due to data bias or programming errors. These risks may limit or delay access to Medicaid beneficiaries, who are more likely to report challenges with PA than other populations (Pollitz et al. 2023). This recommendation would help mitigate some of these risks by clarifying that an individual with expertise must review adverse medical necessity determinations, including those made by automated PA systems. Reviewers can use their expertise to identify and correct course when automated systems make incorrect adverse determinations. In interviews, multiple states expressed that having a human reviewer is a necessary safeguard for automated PA systems, and managed care plans, IT vendors, and states reported that they already require human review of adverse determinations.

This recommendation also addresses the absence of federal guidance on automation in PA and the variation in state approaches to automation. Some states have passed laws requiring human review for adverse PA decisions, while others have not. Guidance would clarify this as a consistent requirement across states, reducing regulatory variation for managed care plans, UM entities, and IT vendors. It would also address concerns that stakeholders raised about the emergence of a patchwork of state laws and policies by providing clear and consistent federal regulatory standards. The recommendation would increase Medicaid alignment with MA regulations, which also require adverse organization determinations be made by individuals with relevant medical expertise (42 CFR 422.566(d)) and made consistent with enrollee-specific circumstances, which CMS clarified cannot be predicted through population-based models alone (42 CFR 422.101(c)(i)(C); CMS 2024b).

Implications

Federal spending. The Congressional Budget Office (CBO) estimates this recommendation would not have an effect on federal direct Medicaid spending.

States. The recommendation would clarify existing regulations under 42 CFR 438.210(b)(3). As such, this would not impose a new requirement on states. From our interviews, many states and their contracted managed care plans have policies and procedures that align with these clarifications. Some states may need to adjust their managed care contracts and oversight processes to ensure that they are adequately governing and monitoring managed care plan compliance consistent with this new guidance.

Enrollees. Ensuring expert oversight of all adverse decisions, including those made by automated systems, may protect beneficiaries from incorrect adverse determinations. Any reduction in the number of incorrect adverse determinations can improve access to care and reduce administrative burdens for beneficiaries seeking care that is subject to PA, particularly for services such as LTSS or behavioral health services that are frequently subject to PA.

Plans. Current managed care regulations require any adverse determination be made by an individual with appropriate expertise. Our stakeholder interviews also indicate that these review provisions are commonly used safeguards in automated PA systems. Therefore, we do not anticipate that plans would need to make substantial changes to their PA processes as a result of this guidance. In the event that some managed care plans must rework existing automation structures to comply with this guidance, those plans may see an increase in administrative burden to modify their policies and procedures.

Providers. PA requests and appeals can create administrative burden and costs for providers. Requiring review of adverse determinations may reduce the number of incorrect adverse decisions issued by managed care plans, which in turn would reduce the administrative burden associated with submitting and appealing those decisions.

Recommendation 2.2

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend the regulations at 42 CFR 440.230 to provide that, for determinations of medical necessity in fee-for-service Medicaid programs, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

Rationale

This recommendation would create alignment between managed care and Medicaid FFS programs. Although Medicaid FFS programs have the authority to implement PA, FFS PA regulations lack the same requirements found in managed care regulations (42 CFR 440.230). Specifically, FFS regulations do not require an individual with expertise to review all adverse decisions. Currently, FFS regulations allow the Medicaid agency to place appropriate limits on a covered service based on such criteria as medical necessity or on utilization control procedures (42 CFR 440.230(d)). There are broad requirements that the Medicaid agency must have an agreement with the state health agency or appropriate medical agency to review the appropriateness and quality of Medicaid services by professional health personnel,

but this is not specifically tied to PA decisions (42 CFR 456.6). The updated regulation should indicate that evaluations by appropriate personnel supporting adverse decisions must reflect the specific medical needs of the enrollee, consistent with the Medicaid managed care regulation. Consistent with the first recommendation, this recommendation would require that, for medical necessity determinations regarding covered benefits, an individual with appropriate expertise must make all denials or partial denials, and denials or partial denials must be made consistent with enrollee-specific medical, behavioral, or LTSS needs. CMS could offer additional clarifying context in the preamble to a proposed regulation articulating the alignment with the managed care regulation and the interpretation of this language with regard to automation. Although state interviewees indicated that the use of automation in FFS is more limited than in managed care, we found no evidence that the standards for PA oversight should differ. Instead, the same risks may arise in PA in both delivery systems.

This recommendation would help mitigate some of the risks posed by automation in PA by clarifying that an individual with expertise must review adverse decisions, including those made by automated PA systems. Such reviewers can use their expertise to identify and correct course when automated systems make incorrect adverse decisions. As noted previously, stakeholders expressed that human oversight is a necessary safeguard for automated PA systems, and managed care plans, IT vendors, and states reported that they already have such policies for adverse decisions.

This recommendation addresses the absence of federal guidance on automation in PA and the variation in state approaches to automation. Regulatory changes for FFS would create consistency for the UM entities and IT vendors that serve Medicaid FFS programs. Creating this consistency addresses the concerns that many stakeholders raised about the emergence of a patchwork of state laws and policies by providing clear and consistent federal regulatory standards.

Aligning FFS and managed care comports with recent federal regulatory action in the imposition of similar requirements across Medicaid payers—for example, the alignment of PA decision time frames required by the interoperability rule. As discussed above, this recommendation would also increase Medicaid alignment with MA regulations (42 CFR 422.566(d), 422.101(c)(i)(C); CMS 2024b).

Implications

Federal spending. CBO estimates this recommendation would not have an effect on federal direct Medicaid spending.

States. In interviews, state FFS programs that use automation in PA indicated that they require clinician review of adverse decisions. However, it is not clear that all states require this safeguard because it is not specified in current federal regulations. Given this, some states may need to implement new clinical reviews and policies in their PA systems. States may need to engage with their internal or external IT teams to modify existing systems to route non-approved PA requests to the required reviewers.

Enrollees. Ensuring oversight of all adverse decisions, including those made by automated systems, may protect beneficiaries from incorrect adverse determinations. Any reduction in the number of incorrect adverse determinations can improve access to care and reduce administrative burdens for beneficiaries seeking care that is subject to PA, particularly for services such as LTSS, behavioral health services, and prescription medications that are frequently subject to PA.

Plans. This recommendation applies to state FFS programs and would not have a direct impact on managed care plans.

Providers. PA requests and appeals create administrative costs for providers. Requiring human review and oversight may reduce the number of incorrect adverse decisions issued by state FFS programs, which in turn would reduce administrative costs associated with submitting and appealing those PA decisions.

Leverage existing authority to increase disclosure and transparency

There is limited transparency into how automated PA systems work and their impact on costs and access to care. Despite having authority to oversee and monitor states' and managed care plans' PA

programs and operations, both CMS and states currently have limited visibility into the adoption and use of automation tools in Medicaid PA. To address this challenge, the following recommendations seek to improve availability of information and data on the use of automation. Improved information and transparency will allow stakeholders to better identify, document, evaluate, and address arising risks associated with the implementation and ongoing use of automation and capitalize more effectively on its benefits.

Recommendation 2.3

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance to state Medicaid agencies and Medicaid managed care plans specifying ways in which existing regulatory oversight processes (42 CFR 438.66), including the external quality review process (42 CFR 438.350) and mandated plan reporting required for Managed Care Program Annual Reports (42 CFR 438.66(e)(1)), can be used to create effective oversight of managed care plans' use of automation in prior authorization.

Rationale

This federal guidance would support states in using existing oversight tools to oversee managed care plans' use of automation, including PA tasks under EQR processes, required appeals and denials reporting for the MCPAR submitted by the state, ongoing managed care monitoring and reporting, and readiness reviews for new managed care contracts. This federal guidance also can recommend that states mandate reporting or other activities that identify the use of and outcomes related to the use of automation in PA under Medicaid managed care contracts.

This recommendation addresses the finding that states have limited insight into managed care plans' use of automation in Medicaid PA. In interviews, no states reported that they have existing or planned mechanisms for collecting data on the use and impact of automation in PA. Absent this information, states are less able to craft informed policy concerning automation in Medicaid PA and are poorly positioned to detect and respond to risks presented by managed care plans' use of automation. A lack of information can also limit states' ability to craft policies that capitalize on the benefits presented by automation.

The recommendation addresses these findings through CMS guidance to states on how they can use existing oversight mechanisms to monitor and oversee managed care plans' use of automation in PA. Examples of the oversight mechanisms this guidance can feature include:

- **Managed care readiness reviews.** State agencies must have an effective monitoring system for all managed care programs under federal regulations (42 CFR 438.66), which include broad-based requirements for monitoring, using monitoring data to improve the managed care program, and readiness reviews for new plans (42 CFR 438.66(b), (c) and (d)). Readiness reviews must include on-site reviews, through which states can require demonstrations of managed care plans' technology platforms, interview UM or IT staff, or otherwise require disclosure and documentation of automation.
- **EQR.** Federal regulations require states to contract with EQROs to conduct regular reviews of managed care plans (42 CFR 438.350–438.370). These reviews must include information on managed care plans' compliance with standards for authorization of services (CMS 2023, 42 CFR 438.358(b)(1)(iii)). Although the EQRO review guidance does not require collection of specific data elements related to UM, or that EQROs assess whether PA denials are clinically appropriate, CMS does develop protocols that states can adopt for interviewing UM staff and assessing UM policies and procedures (CMS 2023). This guidance can include specific examples for states to use, such as model questions or templates included in the EQR protocols.
- **MCPARs.** Federal regulations require states to submit annual reports on their Medicaid managed care programs, known as MCPARs, which includes plan-level data in various program areas. Operationally, states must require plans to report their own data for inclusion in MCPARs and can use contract reporting requirements to specify what must be captured. Currently, MCPARs collect data on appeals and denials at the plan level, but federal policy does not require states to report on the use of automation in PA determinations (42 CFR § 438.66(e)).

CMS guidance can assist states in leveraging these mechanisms to collect information on how managed care plans use automation in the PA process and the impact of PA on their Medicaid programs and beneficiaries. For example, states can use monitoring data to identify the impact of PA on certain services or populations or to identify signs of potential bias in automated PA systems. Some states reported that they lacked the time and resources to develop oversight and monitoring mechanisms and supported CMS issuing guidance on how they can best oversee and monitor managed care plans' use of automation in PA.

The recommendation complements and builds on existing MACPAC recommendations on managed care oversight. In our March 2025 report to Congress, the Commission made recommendations on improving the usability and transparency of findings in the EQR annual technical report. In our March 2024 report to Congress, we made recommendations for CMS to require states to collect and report data on denials and appeals outcomes, report this information in MCPARs, and make the MCPARs publicly available in a format that enables analysis. Finally, in chapter 3 of this report, the Commission issues a recommendation for CMS to develop a publicly available database on managed care plan performance that links federally mandated reported data such as EQR and MCPAR together to facilitate analysis. The data that states collect on automation can be included in such a database and used by states to better understand the impact of automation approaches in different states' programs. Prospective managed care enrollees can also use this database to determine whether managed care plans use automation to process PA requests and if there are any differences in the rate of denials or appeals.

Implications

Federal spending. CBO estimates this recommendation would not have an effect on federal direct Medicaid spending.

States. This recommendation would deliver guidance to states as to how they could structure their current contracts and develop reports to identify the use of and outcomes related to automation in PA as part of existing, required oversight and monitoring activities. It would not mandate that states conduct any additional activities. Implications would vary by state depending on what elements of this guidance they choose to integrate into their practices. States may invest additional resources to conduct these oversight activities, but states would be free to conduct them in a manner that fits within their administrative and financial capacity. State representatives in our interviews reported a lack of information about plans' use of automation as a barrier to effective oversight. States should benefit from the additional transparency and information obtained through these activities.

Enrollees. This recommendation does not directly impact enrollees. Enrollees may benefit if the additional reporting and oversight specific to automation in PA identify potential risks or concerns, such as incorrect adverse determinations, that states and plans can work together to correct.

Plans. This recommendation does not require new reporting elements for managed care plans. As we heard in interviews, some plans may already disclose automation use to states voluntarily. However, states have the flexibility to design and implement disclosure or reporting requirements that vary in breadth or complexity. Managed care plans may incur additional administrative burden to comply with state-determined requirements, such as programming or reconfigurations of reports or demonstrations of system functions.

Providers. This recommendation does not directly impact providers. Providers may experience downstream effects if the additional reporting and oversight specific to automation in PA identify potential issues that lead to changes in PA criteria or processes or improve transparency into payer use of automation.

Recommendation 2.4

State Medicaid agencies should amend their Medicaid managed care plan contracts, on a timeline that is practicable, to require disclosure or other reporting of the use of automation in plans' coverage and authorization processes described at 42 CFR 438.210. Disclosure should facilitate state visibility into the applications of automation tools and other meaningful elements of automation, such as plans' protocols for testing, evaluation, and oversight. To the extent possible, states should modify existing reporting requirements or existing oversight processes to minimize additional administrative burden.

Rationale

States should use existing mechanisms to conduct oversight of managed care plans' use of automation in PA. States can report on various performance metrics in a way that allows for ongoing monitoring of outcomes associated with automation in PA, including demonstrations or documentation during readiness reviews, ongoing oversight activities, or contract-required reporting.

This recommendation addresses the finding that states have limited insight into managed care plans' use of automation in Medicaid PA. States hold unique authority to impose contract standards for plan performance and reporting, such as requiring that plans report if and how they use automation in the PA process. States should use this authority to increase visibility into managed care plans' use of automation in PA and to conduct ongoing oversight of managed care plans. Increased visibility can allow states to craft better automation policies and position them to better detect and respond to risks presented by automation.

Implications

Federal spending. CBO estimates this recommendation would not have an effect on federal direct Medicaid spending.

States. States that adopt this recommendation would need to update their managed care contracts and managed care oversight processes to include new requirements, procedures, and reporting related to the disclosure and monitoring of automation in PA. States may need to invest additional resources to achieve these updates, but states would be free to implement them in a manner that fits within their administrative and budgetary capacity. States should benefit from the additional transparency and information obtained through this action.

Enrollees. This recommendation does not directly impact enrollees. Enrollees may benefit if the additional reporting and oversight specific to automation in PA identifies potential risks or concerns, such as incorrect adverse determinations, that states and plans can work together to correct.

Plans. In states that adopt this recommendation, managed care plans will be required to disclose their use of automation and may need to report additional information to states. Managed care plans may incur additional administrative burden to comply with state-determined requirements, such as programming or reconfigurations of reports or demonstrations of system functions. Managed care plans' adoption or applications of automation may be informed by disclosure requirements, leading to increases or decreases in the overall use of automation.

Providers. This recommendation does not directly impact providers. Providers may experience downstream effects if the additional reporting and oversight specific to automation in PA identifies potential issues that lead to changes in PA criteria or processes or improve transparency into payer use of automation.

Looking Ahead

States and managed care plans use automation to streamline the Medicaid PA process and promote appropriate, cost-effective care. The potential benefits of automation impact all stakeholders: it can reduce costs for states and plans, reduce administrative costs and burdens for providers, and lead to faster or easier approvals for beneficiaries. These benefits carry potential risks that automated systems may produce errors and reduce transparency into the authorization decision process for providers and beneficiaries.

The impact and extent of these risks and benefits is still unknown, as there is currently limited information regarding how payers use automation and its impacts on Medicaid PA. The federal government has not, to date, taken concrete steps to address automation in Medicaid PA or to gather more information on its use. States and private sector actors have taken some steps toward monitoring and governance, but this approach varies, and that variation may create barriers to implementing automation. Federal and state action is warranted to establish a clear and agile framework for the use of automation in PA, increase the availability of information on the use of automation, and ensure protections for beneficiaries.

Endnotes

[1] Medical necessity is not defined in Medicaid regulations or statute. In this chapter, "medical necessity" refers to the assessment of whether care is reasonable and needed for the diagnosis, treatment, or prevention of an illness or injury and fits within the scope of a covered Medicaid benefit.

[2] For a more detailed description of the PA process in Medicaid, refer to MACPAC's issue brief on the subject (MACPAC 2024).

[3] An application programming interface is a set of rules that enables software applications to communicate with each other to exchange data, features, and functionality (Goodwin n.d.).

References

American Medical Association (AMA). 2025. Use of augmented intelligence for prior authorization D-480.956. Washington, DC: AMA. https://policysearch.ama-assn.org/policyfinder/detail/D-480.956?uri=%2FAMADoc%2Fdirectives.xml-D-480.956.xml.

American Medical Association (AMA). 2024. 2023 AMA prior authorization (PA) physician survey. Washington, DC: AMA. https://www.ama-assn.org/system/files/prior-authorization-survey.pdfhttps://www.ama-assn.org/system/files/2023-ama-prior-authorization-survey-question-list.pdf.

Asher, A., K. Contreary, and J. Coopersmith. 2020. *Evaluation of the Medicare prior authorization model for repetitive scheduled non-emergent ambulance transport: Second interim evaluation report*. Washington, DC: Mathematica. https://www.cms.gov/priorities/innovation/data-and-reports/2020/rsnat-secondintevalrpt.

Asher, A., K. Contreary, J. Coopersmith, et al. 2019. *Evaluation of the Medicare prior authorization model for non-emergent hyperbaric oxygen (HBO): Final report*. Washington, DC: Mathematica. https://www.cms.gov/priorities/innovation/Files/reports/mpa-hbo-fnlevalrpt.pdf.

Asher, A., K. Contreary, and J. Coopersmith. 2020. Evaluation of the Medicare prior authorization model for repetitive scheduled non-emergent ambulance transport: second interim evaluation report. Washington, DC: Mathematica. https://www.cms.gov/priorities/innovation/data-and-reports/2020/rsnat-secondintevalrpt.

Bedel, L., D. Delano, D. Brennan, and W. Warring. 2024. *Improving the prior authorization process recommendations for California*. https://www.chcf.org/wpcontent/uploads/2024/07/ImprovingPriorAuthProcess.pdf.

Bipartisan House Task Force on Artificial Intelligence, U.S. House of Representatives. 2024. Bipartisan House Task Force report on artificial intelligence. Washington, DC: Bipartisan House Task Force on Artificial Intelligence. https://www.speaker.gov/wp-content/uploads/2024/12/AI-Task-Force-Report-FINAL.pdf.

Center for Medicare Advocacy. 2022. *The role of AI-powered decision-making technology in Medicare coverage determinations*. Willimantic, CT: Center for American Advocacy. https://medicareadvocacy.org/wp-content/uploads/2022/01/AI-Tools-In-Medicare.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2026. Medicare and Medicaid programs; Patient Protection and Affordable Care Act; interoperability standards and prior authorization for drugs for Medicare Advantage organizations, Medicaid managed care plans, state Medicaid agencies, Children's Health Insurance Program (CHIP) agencies and CHIP managed care entities, and issuers of qualified health plans on the federally-facilitated exchanges. Proposed rule. *Federal Register* 91, no. 71 (April 14); 19890–20062. https://www.federalregister.gov/documents/2026/04/14/2026-07205/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-standards.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024a. Medicare and Medicaid programs; Patient Protection and Affordable Care Act; advancing interoperability and improving prior authorization processes for Medicare Advantage organizations, Medicaid managed care plans, state Medicaid agencies, Children's Health Insurance Program (CHIP) agencies and CHIP managed care entities, issuers of qualified health plans on the federally-facilitated exchanges, Merit-Based Incentive Payment System (MIPS) eligible clinicians, and eligible hospitals and critical access hospitals in the Medicare Promoting Interoperability Program. Final rule. *Federal Register* 89, no. 27 (February 8): 8758–8988. Baltimore, MD: CMS. https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024b. Letter to all Medicare Advantage organizations and Medicare-Medicaid plans regarding "Frequently asked questions related to coverage criteria and utilization management requirements in CMS final rule (CMS-4201-F)." February 6, 2024. https://www.aha.org/system/files/media/file/2024/02/faqs-related-to-coverage-criteria-and-utilization-management-requirements-in-cms-final-rule-cms-4201-f.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023. *CMS external quality review protocols*. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014. *EPSDT—a guide for states: Coverage in the Medicaid benefit for children and adolescents*. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-coverage-guide.pdfhttps://www.aapc.com/codes/webroot/upload/general_pages_docs/document/EPSDT_Coverage_Guide.pdf?srsltid=AfmBOopr7u3tvIjq-Y3E3AXZIy_wNMPf0hrlOhU_pJGdBd0lFDSaZW4ai.

Chen, R.J., J. Wang, D. Williamson, et al. 2023. Algorithm fairness in artificial intelligence for medicine and healthcare. National Biomedical Engineering 7, no. 6. https://pmc.ncbi.nlm.nih.gov/articles/PMC10632090/pdf/nihms-1940941.pdf.

Chu, J., J. Nadler, E. Warren, et al. 2024. Letter from members of Congress to Chiquita Brooks-LaSure regarding "Medicare Advantage plans' use of prior authorization, specifically their ongoing use of artificial intelligence and algorithmic software to guide coverage decisions." June 25, 2024. https://chu.house.gov/sites/evo-subsites/chu.house.gov/files/evo-media-document/Final%20Chu-Nadler-Warren%20Letter%20to%20CMS%20to%20Increase%20Oversight%20of%20AI%20in%20Medicare%20Advantage%20Coverage%20Decisions%2006.25.2024.pdf.

Coalition for Health AI (CHAI). 2026. Our work. Boston, MA: CHAI. https://www.chai.org/our-work.

Committee on Finance, U.S. Senate. 2023. Wyden, Pallone launch investigation into Medicaid managed care plan prior authorization practices. October 3, 2023, press release. Washington, DC: U.S. Senate Committee on Finance. https://www.finance.senate.gov/chairmans-news/wyden-pallone-launch-investigation-into-medicaid-managed-care-plan-prior-authorization-practices.

Dada, M., V. Mundly, C.G. Chambers, et al. 2022. Managing prior approval for site-of-service referrals: An algorithmic approach. BMC Health Services Research 22: 201. https://pmc.ncbi.nlm.nih.gov/articles/PMC8845286/.

Diane, A., P. Gencarelli Jr., J.M. Lee Jr., and R. Mittal. 2023. Utilizing ChatGPT to streamline the generation of prior authorization letters and enhance clerical workflow in orthopedic surgery practice: A case report. Cureus 15, no. 11: e49680. https://www.cureus.com/articles/197161-utilizing-chatgpt-to-streamline-the-generation-of-prior-authorization-letters-and-enhance-clerical-workflow-in-orthopedic-surgery-practice-a-case-report#!/.

Executive Office of the President. 2025. Executive order 14179: Removing barriers to American leadership in artificial intelligence. Presidential Document. *Federal Register* 90, no. 20 (January 31); 8741–8742. https://www.federalregister.gov/documents/2025/01/31/2025-02172/removing-barriers-to-american-leadership-in-artificial-intelligence.

Goodwin, M. n.d. What is an API (application programming interface)? Armonk, NY: IBM. https://www.ibm.com/think/topics/api.

IBM. 2024a. What is an AI model? Armonk, NY: IBM. https://www.ibm.com/think/topics/ai-model.

IBM. 2024b. What is artificial intelligence (AI)? https://www.ibm.com/think/topics/artificial-intelligence.

IBM. 2024c. Generative AI vs. predictive AI: What's the difference? https://www.ibm.com/think/topics/generative-ai-vs-predictive-ai-whats-the-difference.

Jones, M.T. 2019. Machine learning and bias. Armonk, NY: IBM. https://developer.ibm.com/articles/machine-learning-and-bias.

KFF. 2018. Medicaid & CHIP indicators: Medicaid benefits. Washington, DC: KFF. https://www.kff.org/statecategory/medicaid-chip/medicaid-benefits/https://www.kff.org/state-category/medicaid-chip/medicaid-benefits/.

Lubell, J. 2025. How AI is leading to more prior authorization denials. Washington, DC: American Medical Association. https://www.ama-assn.org/practice-management/prior-authorization/how-ai-leading-more-prior-authorization-denials.

Machledt, D., and E. Edwards. 2023. *Principles for fairer, more responsive automated decision-making systems*. Washington, DC: National Health Law Program. https://healthlaw.orgveAutomatedDecisionSystems_05052023.pdf.

Maslej, M., L. Fattorini, R. Perrault, et al. 2025. *Artificial intelligence index report 2025*. https://doi.org/10.48550/arXiv.2504.07139.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2025. *Access in brief: Adults' experiences in accessing medical care*. July 2025. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2025/07/Access-in-Brief-Adults-Experiences-in-Accessing-Medical-Care.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2024. *Prior authorization in Medicaid*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2024/08/Prior-Authorization-in-Medicaid.pdf.

Mello, M.M., A.A. Trotsyuk, A.J.D. Mahamadou, and D. Char. 2026. The AI arms race in health insurance utilization review: Promises of efficiency and risks of supercharged flaws. *Health Affairs* 45, no. 1. https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00897.

Miller, T.C., P. Rucker, and D. Armstrong. 2024. "Not medically necessary": Inside the company helping America's biggest health insurers deny coverage for care. *ProPublica*, October 2023. https://www.propublica.org/article/evicore-health-insurance-denials-cigna-unitedhealthcare-aetna-prior-authorizations.

National Association of Insurance Commissioners (NAIC). n.d. AI Systems Evaluation Tool Pilot: Pilot Project Background. Washington, DC: NAIC. https://content.naic.org/sites/default/files/call_materials/Pilot%20Project%20Summary.pdf

National Association of Insurance Commissioners (NAIC). 2023. NAIC Model Bulletin: Use of Artificial Intelligence Systems by Insurers. Washington, DC: NAIC. https://content.naic.org/sites/default/files/inline-files/2023-12-4%20Model%20Bulletin_Adopted_0.pdf

Office of the Inspector General (OIG), U.S. Department of Health and Human Services. 2022. *Some Medicare Advantage organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care*. Washington, DC: OIG. https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

Permanent Subcommittee on Investigations, U.S. Senate. 2024. *Refusal of recovery: How Medicare Advantage insurers have denied patients access to post-acute care*. Washington, DC: U.S. Senate Permanent Subcommittee on Investigations. https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf.

Pestaina, K., and K. Pollitz. 2022. *Examining prior authorization in health insurance*. Washington, DC: KFF. https://www.kff.org/policy-watch/examining-prior-authorization-in-health-insurance/.

Pollitz, K., K. Pestaina, L. Lopes, et al. 2023. *Consumer problems with prior authorization: Evidence from KFF survey*. Washington, DC: KFF. https://www.kff.org/affordable-care-act/consumer-problems-with-prior-authorization-evidence-from-kff-survey/.

Sahni, N.R., B. Istvan, C. Stafford, and D. Cutler. 2024. Perceptions of prior authorization burden and solutions. *Health Affairs Scholar* 2, no. 9: qxea096. https://pubmed.ncbi.nlm.nih.gov/39328396/.

Speer, M., J.M. McCullough, J.E. Fielding, et al. 2020. Excess medical care spending: The categories, magnitude, and opportunity costs of wasteful spending in the United States. *American Journal of Public Health* 110, no. 12: 1743–1748. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7661971/pdf/AJPH.2020.305865.pdf.

Toner, H. 2023. What are generative AI, large language models, and foundation models? *Center for Security and Emerging Technology*, May 12. https://cset.georgetown.edu/article/what-are-generative-ai-large-language-models-and-foundation-models/.

Tripathi, S., R. Sukumaran, and T.S. Cook. 2024. Efficient healthcare with large language models: Optimizing clinical workflow and enhancing patient care. *Journal of the American Medical Informatics Association* 31, no. 6: 1436–1440. https://pubmed.ncbi.nlm.nih.gov/38273739/.

UnitedHealth Group. 2024. Optum Rx automates prior authorization process for prescription drugs to improve the patient and provider experience. October 22. https://www.unitedhealthgroup.com/newsroom/posts/2024/2024-10-22-optumrx-prior-authorization-process-to-improve.html.

The White House. 2026. *National policy framework: Artificial intelligence*. Washington, DC: White House. https://www.whitehouse.gov/wp-content/uploads/2026/03/03.20.26-National-Policy-Framework-for-Artificial-Intelligence-Legislative-Recommendations.pdf.

APPENDIX 2A: State Legislation on Automation in Medicaid Prior Authorization

TABLE 2A-1. State Laws Affecting Automation in Medicaid Prior Authorization

State	Law	Date passed	Relevant text
Arizona	H.B. 2175	May 12, 2025	Health insurers cannot use AI to deny claims or PA requests; a licensed health care provider must individually review each denial.
California	S.B. 1120	September 28, 2024	AI and algorithms cannot replace health care provider decision making. Any AI or algorithm used in utilization review must rely on the patient's individualized clinical information, and all final approvals and denials must be made by a licensed, clinically competent provider. Plans must ensure AI tools are applied equitably (no bias or discrimination), maintain and disclose written utilization review policies, comply with privacy laws, and remain subject to oversight.
Illinois	H.B. 2472	July 19, 2024	Appeals of automated denials must be reviewed by a qualified clinical peer clinician (not left to automation). Any automated denial process must use objective, evidence-based criteria accredited by a recognized body, such as the National Committee for Quality Assurance.
Indiana	S.B. 480	May 1, 2025	Utilization review entities are required to publish PA requirements online, provide approval and denial statistics, and explain denials or modifications. This law, effective July 1, 2025, excludes fee for service. The state is currently conducting an analysis of its impact on managed care.
Maryland	H.B. 820	May 20, 2025	An AI-based algorithm cannot be the sole basis for denying, delaying, or modifying care based on medical necessity. Payers and pharmacy benefit managers using AI must ensure determinations are based on individual clinical information, not solely group data sets; comply with clinical standards; not replace provider judgment; avoid discrimination; undergo oversight and audits; and be reviewed quarterly for accuracy. AI tools cannot deny, delay, or modify health care services.

TABLE 2A-1. (continued)

State	Law	Date passed	Relevant text
Nebraska	L.B. 77	June 4, 2025	An AI-based algorithm cannot be the sole basis for denying, delaying, or modifying care based on medical necessity. All adverse determinations must be made by a physician or clinical peer. Utilization review entities must disclose to the Department of Insurance, providers, and enrollees and on their public website whether AI is used in PA decisions. The Department of Insurance may audit automated utilization systems, and carriers must annually report PA data (e.g., requests, denials, appeals, and top reasons for denials).
Texas	S.B. 815	June 20, 2025	Utilization review agents are prohibited from using algorithms, AI systems, or automated decision systems to make adverse determinations about medical necessity or coverage (only human reviewers can issue such denials). The insurance commissioner is allowed to audit automated system use. AI may still be used for administrative support or fraud detection.

Notes: AI is artificial intelligence. PA is prior authorization. Minnesota (H. 2500), Pennsylvania (H.B. 1663), and Washington (S.B. 5395) have pending legislation on this topic.

Sources: MACPAC and Mathematica 2025 policy reviews of legislation on automation in the PA process.

APPENDIX 2B: Uses of Automation in the Medicaid Prior Authorization Process

TABLE 2B-1. Uses of Automation in Medicaid Prior Authorization

Steps in the PA process	Pain points	Example automation solutions
Health care provider determines item or service is needed for treatment and places order	• Difficulty keeping track of which services require PA across multiple payers	• Predict future appropriate care settings to expedite PA decisions (predictive AI and algorithms, using clinical data)
Provider contacts Medicaid FFS program or MCO to determine PA requirements	• Complexity and variation in PA rules across payers • Time-intensive manual lookup of requirements	• Identify which services require PA based on payer-specific necessity requirements (deterministic rules-based AI and algorithms, linked to Medicaid or MCO clinical criteria) • Navigate large coverage documentation files to determine coverage (NLP and AI chatbots)
Provider submits required documentation	• Burden of collecting and formatting patient data in correct form • Manual process of submitting required documentation	• Extract structured data from the electronic health record and other sources to fulfill documentation requirements (NLP) • Use generative AI to draft the PA request
FFS program or MCO reviews PA request	• Manual review is time consuming and error prone	• Triage requests to the appropriate reviewer (machine learning) • Extract and classify relevant information from PA documentation (NLP) • Identify requests that can be automatically approved by comparison to established algorithms and clinical criteria (rules-based algorithms) • Flag potential erroneous or fraudulent PA submissions (rules-based algorithms)

TABLE 2B-1. (continued)

Steps in the PA process	Pain points	Example automation solutions
FFS program or MCO issues PA decision, resulting in an approval or denial (which may result in denial appeal)	• Delays in communicating decisions to providers and patients • Lack of clarity for denial reason • Time-intensive appeals process for providers and patients • High rates of overturned denials because of process inefficiencies	• Generate draft denial rationales or approval notices to beneficiary (generative AI)

Notes: PA is prior authorization. AI is artificial intelligence. FFS is fee for service. MCO is managed care organization. NLP is natural language processing.

Sources: MACPAC 2024 and Mathematica 2024 literature and federal policy reviews of the policies, legislation, and regulations that govern automation in the PA process.

Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on May 7, 2026.

Automation in Medicaid Prior Authorization

2.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance to state Medicaid agencies and Medicaid managed care plans clarifying that, for determinations of medical necessity, the language at 42 CFR 438.210(b)(3) requires an individual with appropriate expertise to review and authorize all decisions to deny service authorizations or to authorize a service in an amount, duration, or scope that is less than requested, including those proposed by automated systems. This guidance should clarify further that (1) adverse determinations may not be made by automation tools alone; (2) adverse determinations must be made based on individualized determinations of medical necessity; (3) all existing regulatory requirements related to adverse determinations apply whether or not automation is used in the process of issuing an authorization decision.

2.1 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
No	0	

2.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend the regulations at 42 CFR 440.230 to provide that, for determinations of medical necessity in fee-for-service Medicaid programs, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

2.2 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
No	0	

2.3 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance to state Medicaid agencies and Medicaid managed care plans specifying ways in which existing regulatory oversight processes (42 CFR 438.66), including the external quality review process (42 CFR 438.350) and mandated plan reporting required for Managed Care Program Annual Reports (42 CFR 438.66(e)(1)), can be used to create effective oversight of managed care plans' use of automation in prior authorization.

2.3 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
No	0	

2.4 State Medicaid agencies should amend their Medicaid managed care plan contracts, on a timeline that is practicable, to require disclosure or other reporting of the use of automation in plans' coverage and authorization processes described at 42 CFR 438.210. Disclosure should facilitate state visibility into the applications of automation tools and other meaningful elements of automation, such as plans' protocols for testing, evaluation, and oversight. To the extent possible, states should modify existing reporting requirements or existing oversight processes to minimize additional administrative burden.

2.4 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
No	0	

Chapter 3:

State and Federal Tools for Ensuring Accountability of Medicaid Managed Care Plans

State and Federal Tools for Ensuring Accountability of Medicaid Managed Care Plans

Recommendations

3.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to provide guidance on how to consistently report the types of accountability actions, such as liquidated damages, informal interventions, and other accountability actions taken in response to plan noncompliance, in the sanction section of the Managed Care Program Annual Report pursuant to 42 CFR 438.66(e)(2)(viii).

3.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & 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.

Key Points

- As managed care is the predominant Medicaid delivery system, effective oversight of these programs has increasingly become a priority for stakeholders seeking to ensure that beneficiaries have appropriate access to needed services.
- States use a range of accountability mechanisms to oversee managed care plan performance, including withholds and incentive payments, auto-assignment of enrollees, enrollment freezes, corrective action plans (CAPs), financial penalties such as civil monetary penalties and liquidated damages, and termination of the contract. Most states address identified deficiencies using an incremental, relationship-based approach before escalating to formal sanctions.
- Federal regulation specifies that the Managed Care Program Annual Reports (MCPARs) must include the results of any sanctions, CAPs, or other formal or informal interventions with a contracted plan; however, MACPAC's analysis of MCPARs found that reporting of compliance actions is inconsistent and incomplete. The inconsistency in reporting stems in part from unclear definitions of what should be reported.
- Multiple stakeholders identified challenges in accessing and using available data to assess managed care performance comprehensively. Although CMS requires states to report performance data across a variety of sources, such as the MCPAR, external quality review, and network adequacy and access assurances report, these are not always available in a centralized location or provided in a format that is conducive for analysis that links across plans and states.
- Clarifying reporting requirements for the types of accountability actions that should be reported in the MCPAR and developing a publicly available database that links federally mandated reported data together would provide states, CMS, beneficiaries, and other stakeholders with a more consistent and comprehensive picture of managed care plan performance.

CHAPTER 3: State and Federal Tools for Ensuring Accountability of Medicaid Managed Care Plans

Managed care is now the predominant Medicaid delivery system in most states, growing from less than half (48.3 percent) of Medicaid beneficiaries enrolled in comprehensive, full-risk managed care organizations (MCOs) in fiscal year (FY) 2010 to almost three-quarters (74.1 percent) in FY 2023 (MACPAC 2026a, 2013a). Similarly, managed care capitation payments to all managed care plans have grown from under a quarter (23.5 percent) of Medicaid benefit spending in FY 2010 to over half (57.3 percent) in FY 2023 (MACPAC 2026b, 2013b). With the rise in Medicaid managed care enrollment and spending, effective oversight of these programs has increasingly become a priority for stakeholders seeking to ensure that beneficiaries have appropriate access to needed services. For example, the U.S. Department of Health and Human Services Office of the Inspector General (OIG) has designated oversight of managed care as a priority area, and in 2024, the Government Accountability Office (GAO) called on the Centers for Medicare & Medicaid Services (CMS) to address inconsistencies in MCOs' prior authorization requirements for children's services and limited state oversight of prior authorization actions (GAO 2024a, OIG 2020).

Although CMS and states have made concerted efforts to strengthen oversight of managed care programs, comprehensive information about how state Medicaid agencies use available accountability tools to ensure that managed care plans comply with contract requirements and meet performance expectations has not been made publicly available. Continuing the examination of Medicaid managed care oversight and accountability, MACPAC initiated a study of the tools available to federal and state regulators to oversee states' managed care programs. Specifically, MACPAC staff conducted an environmental scan of federal rules and a review of contracts in states with comprehensive managed care (40 states); held stakeholder interviews with representatives from state Medicaid agencies, managed care plans, and national experts; and analyzed Managed Care Program Annual Reports (MCPARs) available from CMS. MACPAC studied the accountability tools that are available to states and CMS to ensure that managed care plans comply with federal and state requirements and meet performance expectations, which accountability tools are used, and whether states or CMS need additional tools to oversee plan performance.

Our work found that although states had sufficient tools, such as sanctions and incentives to influence plan performance, many stakeholders encounter challenges in using existing data sources to obtain a comprehensive picture of plan performance, both within and across states. Although several measures of managed care plan performance are reported to CMS and made publicly available, these data are reported inconsistently, in part due to unclear definitions. Available data are also fragmented across reports in formats that do not allow for stakeholders to easily combine and analyze. Clarifying certain data definitions and reporting requirements and combining data in a standardized way across federal reports would provide a more consistent, comprehensive picture of managed care performance that would help CMS, states, beneficiaries, and other stakeholders assess past performance and monitor ongoing trends across plans and states. Based on these findings, the Commission makes two recommendations:

3.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to provide guidance on how to consistently report the types of accountability actions, such as liquidated damages, informal interventions, and other accountability actions taken in response to plan noncompliance, in the sanction section of the Managed Care Program Annual Report pursuant to 42 CFR 438.66(e)(2)(viii).

3.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & 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.

These recommendations complement and build on our recent work on denials and appeals in Medicaid managed care and the role of external quality review (EQR) in managed care. In our March 2024 report to Congress, MACPAC examined the monitoring and oversight of denials and appeals in Medicaid managed care and the beneficiary experience with the appeals process. The Commission's recommendations included requiring external medical reviews of denials, clinical audits of denials to assess clinical appropriateness, and CMS and states making denials and appeals data publicly available in accessible formats (MACPAC 2024). In our March 2025 report to Congress, the Commission made three recommendations to improve the EQR process, focused on shifting EQR activities from process and compliance to meaningful outcomes and actionable data and improving the usability of EQR findings through greater reporting consistency, summarization, and transparency (MACPAC 2025).

This chapter begins with background on Medicaid managed care and the federal and state oversight requirements governing Medicaid managed care accountability. The chapter then presents key findings about how states are using various accountability tools and the challenges for stakeholders in using these tools effectively. We then present two recommendations, associated rationale, and implications for stakeholders. The chapter concludes with a look ahead at the Commission's continued work in Medicaid managed care accountability.

Background

Managed care is the predominant Medicaid delivery system in most states (MACPAC 2026a, 2026b). States contract with managed care plans, selecting them through a competitive procurement (request for proposal, or RFP) or a non-competitive application process; the contracts through a competitive procurement typically last three to five years (NAMD 2024). The procurement or application documents establish the state's performance expectations, which are then codified in the contract between the state and its selected plans. The managed care procurement process creates the opportunity for state Medicaid agencies to identify priorities for their program, such as improvements to access, quality, and health outcomes for enrollees. Most states require plans to demonstrate how they would improve the managed care program in their bids and often bind them to the commitments they make in RFP responses in the resulting contracts. However, achieving the goals articulated in the procurement process depends on strong federal and state oversight of plans' contractual obligations.

Although CMS and states have made concerted efforts to strengthen oversight of managed care programs, little is known about how state Medicaid agencies use available accountability tools to ensure managed care plans comply with contract requirements and meet performance expectations. States have access to a range of mechanisms to address managed care plan performance, including withhold and incentive arrangements, reducing or suspending new enrollment (including default enrollment), corrective action plans (CAPs), financial penalties such as civil monetary penalties, fines, and liquidated damages, and termination of the contract. Few studies have systematically examined states' use of these mechanisms or their effectiveness. A recent review of nine state contracts found that states commonly use CAPs to address deficiencies in MCO compliance before imposing fines, which may be levied until the MCO comes back into compliance or brings its performance up to par (Young 2022). If an MCO continues to perform poorly, states may take past performance into account when awarding contracts during the next procurement cycle or even terminate an existing contract (FSSA 2025, MACPAC 2022, Baumgarten 2020).

Federal Requirements on Oversight

In the past ten years, CMS issued three comprehensive updates to Medicaid managed care rules to modernize federal requirements for how states contract for managed care; balance federal oversight and state flexibility; and improve access to care, quality, and outcomes (CMS 2024a, 2020, 2016). In addition, CMS has supplemented this regulatory framework with a series of five informational bulletins since 2021 to provide tools for states and CMS to improve monitoring and oversight (CMS 2026a, 2024b, 2023, 2022, 2021). A few federal rules govern the Medicaid managed care procurement process, and CMS's involvement once contracts are awarded and approved focuses largely on state reporting requirements and providing technical assistance to states. CMS promulgates regulations to establish requirements that govern how Medicaid managed care programs should operate, but CMS generally does not have a direct role in ensuring that managed care plans are complying with federal and state regulations or other contractual terms because CMS is not a party to the contract.

Managed care procurement

As detailed in MACPAC's 2022 managed care procurement study, the federal government defers to states and their respective procurement laws when selecting Medicaid managed care plans (MACPAC 2022). Federal requirements are minimal; states must establish conflict of interest safeguards on the part of state and local officers, employees, or agents of the state who have responsibilities relating to the managed care contracts (42 CFR 438.58).[1] Federal statute and regulation specify the types of organizations allowed to have comprehensive risk contracts in Medicaid (§ 1903(m)(2) of the Social Security Act (the Act) and 42 CFR 438.2). As part of the contract review process, which occurs no less than annually for comprehensive risk contracts, CMS verifies that selected contractors meet the statutory definitions of an MCO or are one of the other types of limited benefit entities (e.g., prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs)) that may hold a risk contract (42 CFR 438.2 and 438.3).[2] However, in large part, states manage their own managed care procurements, deciding whether to have a competitive or non-competitive selection process, the selection criteria, the evaluation panel, how many plans to contract with, the frequency of contract duration, and the content of the contract beyond the required federal provisions.

State Medicaid agency responsibilities

Section 1932(e) of the Act provides that a state may not enter into contracts with MCOs unless the state has established intermediate sanctions that it may impose on an MCO that fails to comply with specified requirements. Federal regulation originally released in 2002 provides the basis for states to establish sanctions and requires states to establish intermediate sanctions on MCOs for specific instances in which the plan acts or fails to act (Table 3-1) (42 CFR 438.700-708). Medicaid managed care rules in 2016, 2020, and 2024 revised certain standards for access, quality, and costs to which state Medicaid agencies hold plans accountable (42 CFR 438). However, imposing sanctions on MCOs is entirely within the state Medicaid agency's discretion. States also have authority to impose additional sanctions under state law or regulation to address non-compliance, including establishing and imposing sanctions on other types of managed care plans (42 CFR 438.702(b)). Ultimately, states retain responsibility for ensuring that their Medicaid program complies with the state plan and federal requirements and cannot delegate these responsibilities to contractors (42 CFR 431.10).

CMS oversight authorities

Federal regulations provide CMS with direct oversight and enforcement authority in specific instances. CMS must approve states' actuarial rate certifications for capitation payments (42 CFR 438.7) and must review and approve state Medicaid agency contracts with managed care plans to ensure they include all federal requirements (42 CFR 438.3). CMS has the authority to deny federal match on state capitation payments to a plan that does not comply with the applicable requirements of Section 1932 of the Act (§ 1903(m)(2)(A)(xii) of the Act).[3]

TABLE 3-1. Intermediate Sanctions States Can Impose on Medicaid Managed Care Plans

Intermediate sanction types (42 CFR 438.702(a))	Reasons for the sanction (42 CFR 438.700) and maximum civil money penalty amount, if applicable (42 CFR 438.704)
Civil monetary penalties	• Failing to provide medically necessary services that the plan is required to provide to enrollees covered under the contract ($25,000 for each determination). • Imposing on enrollees premiums or charges that are more than what is allowed under the Medicaid program (maximum amount is $25,000 or double the amount of the excess charges, whichever is greater. State must deduct from the penalty the amount of overcharge and return it to the affected enrollees). • Discriminating on the basis of health status or need for health care services. Includes termination of enrollment or refusal to reenroll an enrollee (except as allowed under the Medicaid program) or any practice that would reasonably be expected to discourage enrollment by enrollees whose medical condition or history indicates probable need for substantial future medical services ($100,000 for each determination; $15,000 for each beneficiary not enrolled due to a discriminatory practice, subject to an overall limit of $100,000). • Misrepresenting or falsifying information provided to CMS or the state ($100,000 for each determination). • Misrepresenting or falsifying information provided to an enrollee, potential enrollee, or health care provider ($25,000 for each determination). • Failing to comply with physician incentive plan requirements (42 CFR 422.208 and 210) ($25,000 for each determination). • Distributing marketing materials that have not been approved by the state or contain false or misleading information ($25,000). • Violating any requirements in Sections 1903(m) (MCO requirements) or 1932 (provisions related to using managed care in a state) of the Social Security Act or any implementing regulations. Federal regulations do not establish authority to impose civil monetary penalties or appoint temporary management for these violations (42 CFR 438.700(d)(3)).
Appointment of temporary management of an MCO	
Granting enrollees the right to terminate enrollment without cause and notifying them of their right to disenroll	
Suspension of new enrollment, including default enrollment	
Suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or the state is satisfied the sanction is no longer required	

Notes: MCO is managed care organization. CMS is the Centers for Medicare & Medicaid Services. States that contract with an MCO must establish intermediate sanctions that it may impose for the reasons specified. States may establish these sanctions on primary care case management entities. States may also impose additional sanctions under state law or regulation, including establishing and imposing sanctions on other types of managed care plans.

Source: 42 CFR 438, Subpart I.

Federal regulations also authorize CMS to impose sanctions on MCOs through payment denials for new enrollees (42 CFR 438.730). CMS, on the recommendation of the state Medicaid agency, may deny federal match to the state on capitation payments made for new enrollees of an MCO when the plan fails to provide medically necessary services, improperly charges enrollees, discriminates based on health status, provides false information to CMS or the state, misleads enrollees or providers, or fails to comply with physician incentive plan requirements (42 CFR 438.730(a) and (e), 42 CFR 438.700(b)). CMS denial of federal payments for new enrollees automatically triggers denial of state payments to the MCO for those same enrollees (42 CFR 438.730(e)(2)). CMS retains independent authority to perform any enforcement functions normally assigned to the state under this process and refers all determinations resulting in payment denials for new enrollees to the OIG, which may impose additional civil money penalties on the MCO (42 CFR 438.730(g)).

In the 2024 managed care rule, CMS increased managed care oversight through additional reporting requirements, particularly around beneficiary access to care (CMS 2024a). The rule requires states to submit and implement a formal remedy plan for any of its managed care plans when monitoring and oversight activities demonstrate a plan needs improvement in meeting required access to care standards, effective in 2028. States must submit a remedy plan to CMS for approval within 90 calendar days of becoming aware of an access issue. The remedy plan must address the issue and improve access within 12 months and must demonstrate those improvements are measurable and sustainable (42 CFR 438.207(f)).

MCPAR

Federal regulations require states to monitor the performance of each Medicaid managed care plan across several aspects, including areas such as appeals and grievances, medical management, availability and accessibility of services, and quality improvement (42 CFR 438.66(b)). The state must use the data collected from its monitoring activities to improve the performance of its Medicaid managed care program (42 CFR 438.66(c)) and submit an annual report to CMS on several aspects of the program (42 CFR 438.66(e)). States submit the information for this annual report to CMS through a standardized reporting template known as the MCPAR. The MCPAR requires states to report detailed information on their Medicaid managed care programs, including accountability actions such as sanctions and CAPs imposed on managed care plans. Current federal regulation specifies that states must report the results of any sanctions or CAPs imposed by the state or other formal or informal intervention with a contracted plan to improve performance on the MCPAR (42 CFR 438.66(e)(2)(viii)). States began submitting MCPARs in 2022, and CMS has begun posting MCPARs from states on Medicaid.gov.

State Use of Accountability Tools

Our review of 23 recent RFPs and 40 contracts executed between state Medicaid agencies and comprehensive MCOs from 2021 to 2024 found that states typically begin their assessment of plan performance during the procurement by including information about past performance as part of their evaluation criteria. Once contracts were executed, financial sanctions and incentives were the most frequently cited accountability tools used by states. States were also universal in applying sanctions after identifying deficiencies in MCO performance, quality of services, and enrollee access to services.

States vary in their use of past performance during the procurement process. Our review found that all 23 state RFPs required bidding MCOs to provide past performance information in their responses. RFPs most frequently requested that bidders disclose instances of non-renewal or early termination of contracts (17 states), corrective actions or CAPs (16 states), and monetary penalties (12 states). Many states limit the look-back time period for which bidders must report past performance issues. Twenty-one states varied in their look-back period requirements, ranging from 2 to 11 years, while the other two states did not specify the look-back period for which the bidder must disclose past performance issues.

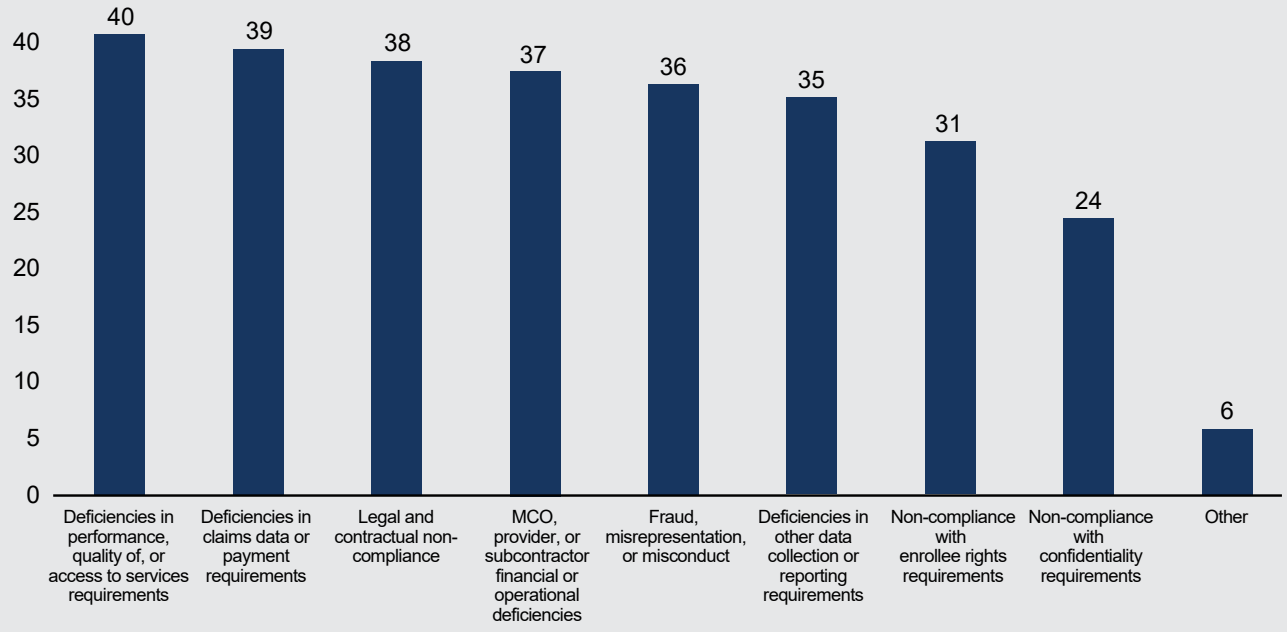
States took a range of approaches in the specific information requested within these broad categories of performance issues and how the information may be ultimately used in awarding a contract. For example, one state primarily used past performance as a tiebreaker between similarly scored proposals, and another included RFP language that would allow the state to refuse to consider any proposal from a bidder who has violated contract provisions. A third state required bidders to explain how they will avoid contract non-compliance in the future even if the bidding MCO did not have deficiencies from the past three years to report.

States include both sanctions and incentives in MCO contracts. As part of our contract review, we classified sanctions into 10 different types: enhanced monitoring and oversight, CAPs, enrollment penalties, capitation payment penalties, other monetary penalties (e.g., fines and liquidated damages), temporary management of a contractor, contract termination, refusal to renew the contract, referral for investigation, and public reporting.

All 40 state contracts reviewed had some type of sanction provisions. The most common sanction types were monetary penalties such as fines and liquidated damages (40 states), CAPs and contract termination (38 states), enrollment penalties (24 states), and capitation payment penalties (21 states). Eighty percent of states (32 of 40) included between five and eight sanction types, with the most being 2 states with eight sanction types.

All 40 states' contracts could impose sanctions in response to identified deficiencies in performance, quality of, or access to services requirements (Figure 3-1). Nearly all states (39 states) had sanction provisions in response to deficiencies in encounter data reporting requirements, claims data, or provider payment requirements. Thirty-eight states specified sanctions for legal and contractual non-compliance.

FIGURE 3-1. Types of Deficiencies that Can Result in Sanctions by Number of States



Note: MCO is managed care organization.

Source: MACPAC and Mathematica, 2024, review of 40 states' publicly available managed care contracts (boilerplate or executed language) executed between 2021 and 2024.

States can push states to meet or exceed specific performance standards through incentive arrangements that can either increase payments or enrollment. We classified incentives that state Medicaid agencies included in their contracts with MCOs into three types: capitation payment bonuses to meet or exceed performance standards or targets, auto-assignment of default enrollees (some states framed auto-assignment as a sanction), and public reporting of MCO performance (some states framed public reporting as a sanction).

All but one of the 40 states included incentives in their contracts to encourage MCOs to achieve or exceed performance standards. Ninety percent (36 of 40) of MCO contracts allowed for capitation payment bonuses when plans meet or exceed certain performance standards or targets, followed by 17 states providing incentives for higher enrollment through the auto-assignment of enrollees.[4] Three states' contract language allowed the state to publicly report individual MCO performance on quality measures and other performance indicators.

States typically address compliance issues informally before escalating to formal sanctions. All state Medicaid agencies interviewed in our study engaged in regular meetings with MCOs to proactively identify and address performance issues. Many states and MCOs reported that informal engagement and iterative informal oversight are the primary tools they use to manage plan performance and resolve issues. These states and MCOs noted that maintaining ongoing communication and relationships is important for addressing and resolving issues before they escalate to formal accountability actions, such as sanctions. All interviewed states discussed maintaining regular touchpoints between MCOs and state staff as an effective approach to developing partnerships and lines of communication to detect and fix problems.

For failure to meet minimum quality standards and first-time offenses, all states interviewed generally addressed issues using informal channels, followed by an escalation or tiered approach to give MCOs an opportunity to correct these types of problems. One state first requires an MCO to submit an MCO Improvement Plan for minor compliance violations, failures, or deficiencies. If the plan does not resolve the issue in a timely manner, the state may escalate to a CAP, followed by the issuance of a fine.

States vary the use of accountability tools based on severity and duration. To determine which accountability tool is most appropriate, some states rank contract violations and performance issues by severity and how quickly the plan resolves the problem. For violations or performance issues that have immediate consequences for enrollees or have not been resolved in a timely manner, all six states interviewed set thresholds that automatically impose a serious penalty, such as a fine or enrollment suspension that involves financial consequences, without giving the MCO an opportunity to remedy the problem through warnings or a CAP.

For problems that do not affect enrollee care directly but that are essential to program operations (e.g., encounter data), some states impose automatic, albeit relatively small, fines. Two states levy fines automatically for incomplete or tardy submission of encounter data, which are required to set capitation rates, monitor utilization and access, and validate plan-reported quality metrics.

The states interviewed as part of this study varied in the criteria they used to determine when to adopt an informal approach or impose formal sanctions. The interviewed states varied in how and when they imposed formal sanctions, and some lacked documented criteria that trigger an escalation, which raises the risk of inconsistency in the application of sanctions to all plans in a state or over time. To have a more consistent process, one state assigns points to non-compliance issues based on the severity and likelihood of recurrence. The accumulation of a certain number of points can trigger formal, escalating sanctions for an MCO. Another state expressed interest in establishing a written, formal escalation policy to ensure the process is clear to all MCOs.

Incentives are often more effective than penalties in motivating improved MCO performance. Incentives, such as bonus payments or a greater proportion of auto-assignment, play an important role in assuring that MCOs meet minimum quality standards and motivating them to improve quality and outcomes. All six study states indicated these

tools are usually effective in modifying or shaping MCO behavior in response to financial motives. If MCOs do not meet the quality goals, they forgo revenue. Interviewed states noted that incentives are more effective if a substantial amount of revenue is associated. According to some national experts, financial penalties may not be a strong motivator for improvement because MCOs often assume a certain level of sanctions as part of their operating expenses. In addition, the dollar value of monetary penalties is often relatively small compared to the almost $500 billion made through Medicaid capitation payments (Table 3-1, MACPAC 2026b).

State officials and MCO representatives discussed the effectiveness of using auto-assignment to motivate MCO performance on quality or performance metrics because enrollment drives a plan's revenue. This can be done as an incentive; by assigning a greater share of new members who do not choose a plan to a high-performing MCO; or, as a penalty, by suspending new auto-assignments. One state indicated that they prefer to suspend auto-assignment instead of suspending all new enrollment into a plan because they did not want penalties that constrict patient choice. Even though auto-assignment can have a significant effect on plan enrollment and revenue, one MCO noted that using auto-assignment as an incentive may not shift behavior substantially if the performance of the MCOs did not vary widely.

Financial sanctions can be challenging to administer. Some interviewees noted that sanctions can be hard to impose because MCOs frequently appeal such enforcement actions, which lengthens the time it takes to resolve the problem. Officials from one state noted that the state was shifting toward incentives because of the delays in resolution resulting from MCO appeals of sanctions.[5] A recent study echoed these challenges; researchers found that approximately 25 percent of sanctions reported in the 2023 MCPARs indicated no remediation action (Ramakrishnan and Tran 2026).

Additionally, the extent to which state Medicaid agencies use available accountability tools can reflect the priorities of the state's executive or legislative branch. A few state officials mentioned that MCOs lobbied the state legislature or governor's office to obtain relief from sanctions. State Medicaid agencies indicated that they are more successful in using accountability tools when legislative and executive support can hold plans accountable for compliance with contract requirements and performance standards.

Public reporting of plan performance is widely recognized as an effective accountability tool. All state officials, national experts, and federal officials recognized public reporting as a tool to promote transparency and accountability, though states vary in the information released and reporting methods. Two study states published quality performance measure results but did not publicly post corrective actions imposed on MCOs. Four of the study states posted CAPs and monetary penalties on state websites throughout the term of the contract.

One state official noted that public disclosure often motivates the plans to resolve issues, so public reporting is seen as one of their most effective accountability tools. Federal and national experts agreed that public reporting of MCO performance, including sanctions, generally is an important tool for driving improvements in MCO performance and better outcomes for enrollees but emphasized that it needs to be in an accessible, understandable format to be effective. One national expert noted that public reporting is critical for informing policymakers, providers, enrollees, and the general public about MCO performance. Enrollees could use the performance and sanctions data to reconsider their MCO choice if a plan was repeatedly sanctioned or had CAPs imposed.

MCO representatives acknowledged that public reporting can be an important accountability tool and were not opposed to disclosure of plan performance, including sanctions. However, they expressed the need to place information in the appropriate context. For example, one plan representative expressed concern about posting information on sanctions that are still undergoing the appeals process.

Challenges in Oversight and Accountability

The environmental scan, stakeholder interviews, and MCPAR analysis identified several challenges and opportunities related to managed care accountability and oversight. States generally have sufficient tools to oversee plan performance and typically use an incremental, relationship-based approach before escalating to formal sanctions. However, the findings surfaced concerns about the consistency and completeness of MCPAR data; CMS's ability to directly address deficiencies within state managed care programs; and the availability and usability of managed care performance data to support state actions, such as procurement and oversight decisions.

CMS has broad authority to oversee state managed care programs but limited tools to address specific deficiencies

Although CMS has broad authority to ensure that state Medicaid managed care programs are structured to be compliant with federal requirements, it has fewer tools to directly address specific deficiencies because states are the primary managers of plan performance due to their direct contractual relationship with the plans. CMS uses several tools to ensure state and managed care plan accountability following review and approval of state MCO contracts. CMS staff conduct ongoing, regular communication and monitoring calls with states. If CMS learns of plan compliance or performance problems through meetings or provider or beneficiary complaints, CMS staff can issue compliance letters informing the state of the issue, provide technical assistance to the state regarding possible remedies, and/or modify Section 1115 or 1915(b) waiver terms and conditions, if applicable, that clarify compliance and monitoring expectations.

CMS can defer or withhold federal matching funds only for the entire amount of the capitation payment made to MCOs. In practice, CMS rarely uses this authority because deferring or withholding funding for the entire capitation payment can disrupt the financing of all beneficiary care provided through the managed care plan and not just the particular issue that needs to be addressed. CMS may have authority to impose sanctions directly on managed care plans in certain situations (42 CFR 438.730(g)). However, CMS officials indicated that to do so, they must have documented evidence that the managed care plan committed a deficiency and that the deficiency harmed the beneficiary. These officials did not recall using this authority over the past several years. Although federal officials generally agreed that states are primarily responsible for ensuring that plans meet performance expectations, they also acknowledged they lack some of the administrative tools that are otherwise available to oversee a fee-for-service (FFS) program. These officials suggested that in some cases, it would be useful if CMS had the same statutory authority as they have in FFS, such as the authority to impose formal CAPs on states or defer or withhold a share of the federal match for capitation payments in proportion to the severity of non-compliance or performance issue.

State Medicaid officials and MCOs agreed that contract monitoring and enforcement should be managed by states and that additional CMS involvement in contract compliance is unnecessary. As CMS sets the minimum standards through federal regulation and guidance, state Medicaid agencies believe the standards afford them the flexibility they need to decide how and in what circumstances to use various accountability tools.

The Commission considered an amendment to Section 1903(m) of the Act to authorize CMS to withhold, defer, or disallow federal match for all or part of a managed care capitation payment, proportional to the severity of non-compliance with existing federal requirements. This approach would have been analogous to CMS's existing authority to defer or disallow federal match in proportion to non-compliance in FFS programs. Although some Commissioners noted that a proportional deferral authority in managed care could be more credible and targeted, the Commission ultimately decided not to proceed with a recommendation. Some Commissioners raised concerns about federal intervention in the state-contracted relationship with MCOs, the breadth of the proposed authority without sufficient guardrails or specification of remedial steps, and the potential for arbitrary or disproportionate disruption to beneficiary care. Commissioners also noted the practical challenge of quantifying what portion of a global capitation payment should be attributable to a specific deficiency.

Inconsistent and incomplete MCPAR reporting limits data usability

To supplement our environmental scan and stakeholder interviews, we reviewed and analyzed the MCPARs submitted for comprehensive MCO programs for performance year 2023, which includes contracts that were in effect on June 30, 2024, representing 34 states. The MCPARs include information on sanctions and CAPs states imposed on their managed care plans during the reporting period. Our analysis focused on the types of sanctions, amount of financial penalties, reported reasons for the intervention, and time to remediation.

MCPAR reporting appears to undercount the actual use of accountability actions. States began submitting MCPARs in 2022, which include information on sanctions, CAPs, and other accountability tools states imposed on their managed care plans. However, a 2024 GAO review of state MCPARs for performance year 2022 found reporting was inconsistent and incomplete (GAO 2024b). Based on our analysis of the number and type of sanctions reported in MCPARs for the states examined in this study, it is likely that states are not reporting all compliance actions in MCPARs. We compared findings in the MCPARs to publicly available state-level information on plan sanctions or other compliance actions and found inconsistencies in the reporting.

In our interviews, state officials indicated that they often pursue informal accountability actions before escalating to formal sanctions. All state Medicaid agencies interviewed engaged in regular meetings with MCOs to proactively identify and address performance issues, and all states interviewed generally addressed issues using informal channels before issuing formal sanctions, using an escalation approach to oversight. Our analysis of performance year 2023 MCPARs echoed these findings; states were more likely to take intermediary steps such as CAPs versus monetary penalties (25 states issued 359 CAPs; 11 states issued 106 civil monetary penalties) (Table 3-2).

We found evidence that the MCPAR sanctions data do not necessarily align with other reports. For example, one state did not report any liquidated damages in their MCPAR sanctions, but according to the state's website, their managed care compliance actions totaled $33.8 million in liquidated damages for state fiscal year 2024 (July 1, 2023–June 30,2024) and one sanction of $2,500 (AHCA 2025). The MCPAR data reflect the $2,500 sanction but fail to capture the liquidated damages. The National Health Law Program has also studied variation in compliance actions reported on MCPARs and found evidence that states are not reporting liquidated damages consistently (Young 2025).

TABLE 3-2. Financial Sanctions by Sanction Type

Sanction type	Number of sanctions	Number of states with sanction type	Number of sanctions with financial penalty	Average sanction amount
Civil monetary penalty	106	11	106	$402,833
Corrective action plan	359	25	12	590,047
Corrective action plan and liquidated damages	19	2	18	124,552
Liquidated damages	187	10	184	37,962
Compliance letter	66	8	0	0

Notes: Managed Care Program Annual Report (MCPAR) submissions categorized as both corrective action plan and civil monetary penalty were excluded due to the small sample size (two submissions). One MCPAR submission did not have data available on the sanction type. The average sanction amount includes only sanctions with an associated financial penalty; sanctions reported as "N/A" or "$0" for financial amount were excluded from the average.

Source: MACPAC, 2025, analysis of state-submitted MCPARs in performance year 2023 (34 states).

CMS has provided written guidance and frequently asked questions to help states submit complete and accurate data across the MCPAR's program areas, including the scope of sanctions states must provide (CMS 2024a, 2024b). Although CMS can ask states to submit corrected data, it has few tools to ensure states submit accurate data. In its 2026 informational bulletin, CMS discussed implementation of a Medicaid Managed Care Oversight Review (MCOR) in 2025 as part of an effort to develop monitoring and oversight tools. As part of the first set of MCORs that started in December 2025, CMS is conducting review activities to analyze how states are using sanctions in managed care plans (CMS 2026a).

State variance in MCPAR reporting reflects unclear definitions of what should be reported. Federal regulation specifies that the MCPAR include the results of any sanctions or CAPs imposed by the state or other formal or informal intervention with a contracted managed care plan to improve performance (42 CFR 438.66(e)(2)(viii)). Although CMS requires states to report formal and informal interventions, the current MCPAR instructions do not provide sufficient clarity on what constitutes "informal interventions" or how to appropriately report various accountability actions. For example, it is unclear whether states should report activities such as verbal warnings during routine monitoring calls, requests for additional data or information about compliance issues before formal intervention, or informal performance improvement discussions. CMS has released technical assistance materials but did not include additional definitions of "informal" or how to report various types of accountability actions like liquidated damages. In MCPAR guidance on frequently asked questions from August 2025, CMS stated that the "scope of sanctions" collected in MCPARs "includes, but is not limited to, financial penalties, CAPs, suspension of enrollment, written warnings, and other formal or informal intervention with a contracted plan to improve performance" (CMS 2025). This broad language leaves room for interpretation regarding which specific oversight actions states should report and how to categorize them.

MCPARs are in the early years of implementation, so states may be getting used to the reporting process and definitions. In our interviews, some state officials and national experts suggested CMS has an opportunity to require that this information be more complete and transparent across states. For instance, some state officials suggested that CMS develop a contract violations template that could be used to assess and track the past performance of plans; such a template could build on the sanctions section of the MCPAR. MACPAC previously made recommendations to improve the usability of denials and appeals data included in the MCPARs, recognizing the ongoing need for clarity in MCPAR reporting standards across multiple program areas (MACPAC 2024).[6]

Managed care performance data are siloed across multiple reporting systems and are difficult to access and compare

Multiple stakeholders identified challenges in accessing and using available data to assess managed care performance comprehensively. Although CMS requires states to report performance data across a variety of sources, such as the MCPAR, EQR, and network adequacy and access assurances report (NAAAR), these are not always available in a centralized location or provided in a format that is conducive for analysis that links across plans and states. These data are not publicly available in a comprehensive or user-friendly format that states can easily leverage to assess plan performance or that beneficiaries can use to inform their choice of plan.

Several interviewees suggested that CMS could help states by developing a national database of managed care contract violations and sanctions to support transparency and state efforts to contract with high-performing plans. Additionally, interviewed states indicated that a national, publicly available dataset on managed care performance would assist them with refining their routine monitoring and oversight activities. Although the interviewed states all review past performance in their evaluation of bids to understand potential performance problems, they vary widely in the look-back periods for which bidders must disclose issues and the types of disclosures they require. In addition, the information on past performance submitted by plans is specific to each state procurement and cannot be used by other states. CMS and states are already collecting data on managed care performance and sanctions,

but it has historically not been publicly available in a comprehensive or user-friendly format.[7]

National experts noted that the MCPAR is a good first step in collecting plan-level sanctions data but that CMS could do more to help state Medicaid agencies better understand managed care plan performance in other states, such as repeat problems across multiple states. They suggested that a database or a dashboard that keeps the data dynamic, up to date, accurate, and comprehensive would allow states to understand sanctions across the country.

Commission Recommendations

The Commission makes the following recommendations to improve the usability of managed care performance data and provide states with additional guidance and tools to more effectively assess and oversee plan performance.

Recommendation 3.1

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to provide guidance on how to consistently report the types of accountability actions, such as liquidated damages, informal interventions, and other accountability actions taken in response to plan noncompliance, in the sanction section of the Managed Care Program Annual Report pursuant to 42 CFR 438.66(e)(2)(viii).

Rationale

Current federal regulation specifies that the MCPAR must include the results of any sanctions or CAPs imposed by the state or other formal or informal intervention with a contracted managed care plan to improve performance (42 CFR 438.66(e)(2)(viii)). However, as identified in our analysis, states are likely reporting inconsistent or incomplete data, and it is not clear that states share the same definitions of sanctions and informal interventions.

The inconsistency in reporting stems in part from unclear definitions of what should be reported. As discussed above, one state's reporting of liquidated damages exemplifies this problem; the state reported $33.8 million in liquidated damages on its own compliance dashboard but none on its MCPAR (AHCA 2025). This discrepancy in reporting likely reflects a difference in how the state and CMS view liquidated damages. In its report, the state defines liquidated damages separately from sanctions and indicates that liquidated damages are not considered a penalty.

Similarly, states appear to vary in their reporting of informal interventions. As noted in our stakeholder interviews, states commonly use informal accountability actions before escalating to formal sanctions. The MCPAR includes an intervention type for all compliance-related notices or letters (e.g., warnings, non-compliance). Because most states use an escalation process, states typically issue either informal or formal warnings before imposing CAPs or financial penalties. However, fewer states (8 states) reported issuing compliance letters than either CAPs (25 states) or civil monetary penalties (11 states) in the performance year 2023 MCPARs (Table 3-2). Likewise, a 2024 GAO review of state MCPARs for contracting year 2022 found reporting was inconsistent and incomplete (GAO 2024b). CMS subsequently provided written guidance to help states submit complete and accurate data, but additional clarification is needed to ensure consistent reporting across states.

Given that CMS and states recently started reporting data through MCPARs, this is an opportune time for CMS to provide additional guidance and standardization. MACPAC previously made recommendations in its March 2024 report to Congress to improve the usability and transparency of denials and appeals data included in the MCPARs, recognizing that clear data definitions and reporting instructions are essential for making MCPAR data useful for oversight and monitoring purposes.

This recommendation would provide guidance on the types of accountability actions that should be reported on the MCPARs. Specifically, CMS should clarify reporting requirements for liquidated damages, informal interventions that states may use before escalating to formal sanctions, and other accountability actions that respond to plan non-compliance. CMS should determine a clear threshold for reporting informal interventions and provide examples to distinguish routine oversight activities from reportable compliance events. The goal of this recommendation is not to

document every communication between the state and managed care plan or to dampen states' ability to communicate informally with their plans, but to capture notable communications and interventions in response to a lapse in plan performance. For example, CMS could exclude routine monitoring calls from reporting.

Improved MCPAR data quality and completeness would enhance CMS's ability to oversee state managed care programs and identify patterns of compliance issues across states and plans. More consistent and complete data would allow for better understanding of how states use accountability tools and assessment of the effectiveness of different accountability approaches.

This recommendation is not intended to create new data collection requirements or impose new reporting burdens beyond what is already required in regulation. Rather, it seeks to clarify what should be reported under existing requirements and standardize how states report this information to ensure consistency and completeness. CMS would need to identify where additional clarification and standardization are needed, which could involve consulting with states about the range of compliance actions they take and reviewing the variation in current reporting to understand which definitions or instructions would be most helpful. CMS should seek a balance in obtaining a clear picture of states' accountability actions and minimizing state burden in reporting. CMS should solicit feedback from states on how to strike a balance between capturing accurate data and ensuring only meaningful compliance actions are reported. This recommendation would apply to all managed care plans that submit MCPARs, including MCOs, PIHPs, PAHPs, and primary care case management (PCCM) entities.

Implications

Federal spending. The Congressional Budget Office (CBO) does not estimate any change in federal direct spending. The recommendation may result in increased administrative effort such as developing and disseminating updated instructions, data definitions, and reporting templates through technical assistance materials, MCPAR instruction updates, or subregulatory guidance.

States. States already collect information on their accountability actions and are required to submit this information on MCPARs. The primary change would be more specific guidance on what and how to report, rather than requiring states to collect new information. However, some states may need to adjust their internal tracking systems or processes to ensure they are capturing and reporting all required information consistently. States could benefit from more complete and accessible data on compliance actions to help assess plan performance as part of the procurement process and benchmark their use of accountability tools against other states. Improved MCPAR data quality and completeness would enhance the usability of these data for assessing and monitoring plan performance by state Medicaid agencies. More consistent and complete data would allow for better understanding of how states use accountability tools, identification of patterns across states, and assessment of the effectiveness of different accountability approaches.

Enrollees. Improved MCPAR data quality would enhance transparency regarding how states hold plans accountable for performance. More complete and publicly accessible information on sanctions and other accountability actions could help beneficiaries make more informed choices during plan selection and could create additional incentives for managed care plans to improve the quality of and access to care being provided.

Plans. Managed care plans should not see a substantial increase in administrative burden because they are not directly submitting MCPAR data. However, plans may face indirect effects if states request additional documentation to support more complete MCPAR reporting. Standardized reporting could benefit plans by creating consistent expectations across states regarding what constitutes reportable accountability actions and by making reported plan performance comparable through reduced variation.

Providers. Although this recommendation would not directly change providers' operations, providers could benefit from complete and publicly accessible information on plan performance. Providers must make decisions about contracting with plans, and access to standardized performance data could inform those contracting decisions.

Recommendation 3.2

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & 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.

Rationale

Several stakeholders mentioned challenges in accessing and using managed care performance data across states for comparison or benchmarking. Although CMS requires states to report performance data across a variety of sources (e.g., NAAAR, MCPAR, EQR, and the Quality Rating System (QRS)), these are not always available in a centralized location or provided in a format conducive to analysis.[8] Although states can assess the performance of their plans, they also seek information on plan performance in other states. For example, states often ask for information on past performance during procurement; however, it can be challenging to compare in-state and out-of-state performance when each state and plan highlights different metrics.

Several interviewees suggested that CMS could help states by developing better tools to access and compare managed care performance data program-wide. National experts noted that although the MCPAR is a good first step in collecting plan-level data, understanding plan performance across states remains difficult. They suggested that CMS could help state Medicaid agencies better understand plan performance in other states, such as repeat problems across years or multiple states. They suggested that a publicly available, comprehensive, up-to-date database would provide states a standardized way to access data on plans' prior performance, such as sanctions. States could benchmark their programs' outcomes and compliance data compared to other states. This type of comparison could help states identify gaps in their oversight practices or identify emerging trends in other states that should be monitored. Although the data included from the MCPAR or EQRs would be lagged due to the nature of retrospective reporting, states and other stakeholders could benefit from viewing historical data trends and plan-level reports. Additionally, CMS guidance and toolkits on how to use the database effectively could help some states better structure their own internal data and reports for real-time monitoring of their plans.

CMS developed a Medicaid Data Collection Tool (MDCT) to collect data required to monitor, manage, and review the managed care programs for each state, which includes a Managed Care Reporting (MCR) web portal that states use to submit MCPARs, NAAARs, and medical loss ratio reports (CMS 2025, 2023). This portal provides a structured system that allows CMS to generate and analyze state-specific and nationwide data across all managed care programs and requirements, and it can be used to identify areas for improvement and target technical assistance to states (CMS 2026a). Although this database is not available to the public, CMS could build on this structure to develop a comprehensive public-facing database or dashboard that states and enrollees can use to understand managed care performance. Box 3-1 describes managed care data sources that potentially could be linked in a public-facing resource.

This recommendation builds on the Commission's prior work on managed care oversight. In our March 2025 report to Congress, the Commission made recommendations on EQRs, including the need to reduce areas of duplication with other federal quality and oversight reporting requirements; create a more standardized structure in the annual technical report that summarizes EQR activities, results, and actions taken by state Medicaid agencies; and identify key takeaways on plan performance. This option would build on those prior recommendations by combining the information across the different federal reports on managed care quality and oversight. Additionally, it would allow stakeholders to view EQR activities, sanctions, or other oversight actions to track the outcomes of compliance actions over time. Plan representatives have noted that any public reporting should be put into appropriate context. Combining information across data sources could provide that additional context to specific metrics, which may reflect differences in state procedures and benchmarks instead of overall plan performance. For example, states may have different standards and benchmarks

to determine when to assess sanctions. Combining information on sanctions from the MCPAR with EQR findings on the development and validation of performance measures and QRS metrics on access and quality outcomes would provide additional context and a more holistic view of plan performance than just a count of sanctions itself.

CMS could also benefit from a more holistic view of state and plan compliance with federal requirements through better integration of existing data sources. The development of a public-facing database could strengthen CMS's role in assessing the performance of states' managed care programs and improve the overall quality of managed care oversight at the federal level. Furthermore, stakeholders such as consumer advocates and researchers could use comprehensive performance data to identify systemic issues affecting beneficiaries.

BOX 3-1. Sources of Managed Care Performance Data

States and managed care plans are required to report managed care performance data across several different reports and systems.

- **Managed Care Program Annual Report (MCPAR):** The MCPAR is a standardized reporting template that all states with managed care programs must submit annually to the Centers for Medicare & Medicaid Services (CMS) (42 CFR 438.66(e)). MCPARs capture a wide range of information at the plan level, including information on financial performance, encounter data submission, grievance and appeals, quality measures, and sanctions. States submit this report through the Medicaid Data Collection Tool for Managed Care Reporting (MDCT MCR) web portal.
- **Network Adequacy and Access Assurances Report (NAAAR):** The NAAAR requires states to submit an assurance of compliance to CMS that each contracted managed care plan meets the state's requirement for availability of service and to include documentation of a network adequacy analysis (42 CFR 438.207(d)). In 2025, CMS began gathering these data in the MDCT MCR (CMS 2026).
- **Medical Loss Ratio Report (MLR):** Each managed care plan under contract submits an annual MLR report to the state, including the percent of revenues that plans spend on services, activities that improve health care quality, and fraud prevention activities (42 CFR 438.8). States use these data to submit an MLR summary report annually to CMS (42 CFR 438.74(a)). States submit this summary report through the MDCT MCR web portal.
- **External quality review (EQR):** A state must contract with an EQR organization to review and validate the performance of their contracted managed care plans on an annual basis (42 CFR 438 Subpart E). The EQR must include four mandatory activities: performance measurement validation, performance improvement project validation, compliance review, and network adequacy validation, and states may add optional review activities as well (42 CFR 438.358). States must publish EQR findings in an annual technical report that includes an assessment of each plan's strengths and weaknesses regarding quality, timeliness, and access to services and recommendations for improvement (42 CFR 438.364).
- **Medicaid and CHIP Quality Rating System (MAC QRS):** States that operate a managed care program must implement a MAC QRS by December 31, 2028. The MAC QRS will be a state-run public website that provides information on quality measures and ratings for managed care plans (42 CFR Part 438 Subpart G).

As part of their understanding of managed care performance data, some national experts suggested that CMS develop guidance about the necessary state capacity to support managed care procurement, such as staff experience and qualifications, design of evaluation criteria, and contract provisions that ensure states have sufficient accountability tools. They noted that CMS could help develop state capacity in procurement, perhaps through a state learning collaborative. Specifically, they suggested guidance on selecting standardized indicators of past performance to include in the RFP to compare bidders. States frequently use past performance as a component of their procurement decisions, and this recommendation would provide a standardized way to collect this information across all plans that would be readily available if a state wishes to use it. Currently, it can be challenging to compare plans if each plan highlights different metrics. Additionally, states could use the database to identify patterns of compliance problems across years or in multiple states that could be reflected through reduced scoring during procurement or the addition of enhanced monitoring provisions to the standard contract. CMS routinely provides technical assistance to states and has indicated that states may request direct technical support on managed care program planning and procurement; however, information has not been disseminated broadly like other monitoring and oversight toolkits the agency has published on its website (CMS 2026b, 2026c).

Implications

Federal spending. The CBO does not estimate any change in federal direct spending. To implement this recommendation, CMS would develop a public database that combines existing data sources, possibly using an available chassis such as the MDCT MCR as well as supporting guidance materials and facilitating state learning collaboratives. CMS would need to identify the database requirements and publish the data in a format that enables analysis. These investments could lead to more effective oversight and better use of existing data resources across the agency as well as for states.

States. This recommendation would provide states with complete and standardized plan performance data that could improve their ability to procure high-performing plans and implement effective accountability provisions in contracts. The recommendation would not increase the administrative burden on states because CMS would be responsible for linking and updating the data. States would collect and report the same data that are currently required. However, some states may need to adjust their internal tracking systems or processes to ensure they are capturing and reporting all required information consistent with federal reporting expectations.

Enrollees. Performance data that are publicly available and readily accessible can improve the ability of beneficiaries to assess plan performance and make informed decisions during plan selection. Beneficiaries could make more informed plan choices. Improved plan performance resulting from more effective state oversight could lead to better access to care and quality of services for beneficiaries.

Plans. Plans should not see an increase in administrative burden because the recommendation would use data that plans are already reporting. More standardized assessment approaches across states could reduce administrative burden for plans operating in multiple states, and these national carriers could benefit from improved comparability of their performance in different states. Combining information across data sources could provide additional context to specific metrics and provide a more complete picture of overall plan performance.

Providers. Although this recommendation would not directly change providers' reporting operations, providers could benefit from complete and publicly accessible information on plan performance. Providers must make decisions about contracting with plans, and access to standardized performance data could inform those contracting decisions.

Next Steps

The recommendations in this chapter build on MACPAC's ongoing work examining effective oversight of Medicaid managed care programs to ensure beneficiaries have appropriate access to needed services. These recommendations address near-term opportunities to improve the completeness and usability of existing federally mandated data and to equip states with the guidance and tools to translate that data into stronger oversight and procurement decisions.

Looking ahead, the QRS represents an important development in the landscape of managed care accountability. CMS finalized a framework for the Medicaid QRS in the 2024 managed care rule, and states must implement the QRS, which includes 16 mandatory metrics, by December 31, 2028 (42 CFR 438, Subpart G). When implemented, the QRS will add a standardized, publicly reported layer of plan performance information that should be incorporated into the public data resource recommended in this chapter. The Commission will continue to monitor the implementation of QRS and other requirements from the 2024 managed care rule as they take effect.

The Commission will continue to monitor the maturation of MCPAR reporting. MCPARs are still in the early years of implementation. CMS has already taken steps to improve data quality through technical assistance and guidance and CMS is planning to implement validation checks on certain data at the point of MCPAR submission in MDCT (CMS 2026a). The Commission will examine whether additional steps are needed to ensure MCPARs become a reliable, comprehensive source of accountability data across states and plans.

Endnotes

[1] These safeguards must be at least as effective as those specified in Section 27 of the Office of Federal Procurement Policy Act, which limits communications and activities of personnel involved in the development and submission of proposals to federal agencies.

[2] Section 1903(m)(1)(A) of the Act defines an MCO: The term "medicaid managed care organization" means a health maintenance organization, an eligible organization with a contract under section 1876 or a Medicare+Choice organization with a contract under part C of title XVIII, a provider sponsored organization, or any other public or private organization, which meets the requirement of section 1902(w) and—(i) makes services it provides to individuals eligible for benefits under this title accessible to such individuals, within the area served by the organization, to the same extent as such services are made accessible to individuals (eligible for medical assistance under the State plan) not enrolled with the organization, and (ii) has made adequate provision against the risk of insolvency, which provision is satisfactory to the State, meets the requirements of subparagraph (C)(i) (if applicable), and which assures that individuals eligible for benefits under this title are in no case held liable for debts of the organization in case of the organization's insolvency." In the implementing regulations at 42 CFR 438.2, an MCO are defined as an entity that has, or is seeking to qualify for, a comprehensive risk contract.

[3] CMS, on the recommendation of the state Medicaid agency, may also deny federal match to the state on capitation payments made for new enrollees of an MCO when a state's MCO acts or fails to act in six circumstances (§ 1903(m)(5)(A) of the Act, 42 CFR 438.730): fails substantially to provide medically necessary services to an enrollee; improperly charges enrollees for services; discriminates against enrollees based on their health status or need for services; provides false or misleading information to CMS or the state; provides false or misleading information to enrollees, potential enrollees, or providers; and fails to comply with physician incentive plan requirements.

[4] States may consider several criteria to conduct default enrollment (also called auto-assignment), including quality assurance and improvement performance and procurement evaluation elements (42 CFR 438.54(d)(8)(ii)).

[5] Due process for appealing enforcement actions can vary across states. Regulations only require that the state must give the affected MCO timely written notice that explains the basis and nature of the sanction and any other appeal rights that the state elects to provide, with the exception that states must provide a hearing before terminating an MCO contract and cannot delay imposition of temporary management to provide a hearing (42 CFR 438.710, 438.708, 438.706(c)).

[6] In the March 2024 report to Congress, the Commission made seven recommendations on denials and appeals in managed care, including requirements for states to conduct routine clinical audits of denials and to collect and report data on denials, beneficiary use of continuation of benefits, and appeals outcomes. As part of these new requirements, the Commission recommended CMS update the MCPAR template to include data on the results of the clinical audit and denials, beneficiary use of continuation of benefits, and appeal outcomes, using standardized definitions for reporting. Additionally, CMS should publicly post all MCPARs to the CMS website in a standard format that enables analysis, and CMS should require that states include denials and appeals data on their QRS websites (MACPAC 2024).

[7] On April 30, 2026, CMS published the first public use file (PUF) of MCPAR data for performance year 2024. These data were not available during the course of MACPAC's study, but the PUF does provide the MCPAR data in a publicly available format that enables analysis.

[8] States must implement the QRS by December 31, 2028 (42 CFR 438.404(a)(2)).

References

Baumgarten, A. 2020. *Analyzing Medicaid managed care organizations: State practices for contracting with managed care organizations and oversight of contractors*. Princeton, NJ: Robert Wood Johnson Foundation. https://www.rwjf.org/en/insights/our-research/2020/08/analyzing-medicaid-managed-care-organizations--state-practices-for-contracting-with-managed-care-organizations-and-oversight-of-contractors.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2026a. Center for Medicaid and CHIP Services informational bulletin regarding "Medicaid and CHIP managed care monitoring and oversight tools." March 12, 2026. https://www.medicaid.gov/federal-policy-guidance/downloads/cib03112026.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2026b. Technical assistance: Medicaid managed care—individualized technical assistance for states. https://www.medicaid.gov/medicaid/managed-care/technical-assistance.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2026c. Medicaid and CHIP managed care monitoring and oversight initiative. https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-monitoring-and-oversight-initiative.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2025. *Medicaid managed care program annual report (MCPAR): Technical assistance resource for states*. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/downloads/mcpar-faq-v3.0-07.31.25.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024a. Medicaid program; Medicaid and Children's Health Insurance Program (CHIP) managed care access, finance, and quality. Final rule. *Federal Register* 89, no. 92 (May 10): 41002–41285. https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024b. *Managed care program annual report (MCPAR) technical guidance: Topic: Appeals and grievances*. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/managed-care/downloads/mcpar-appeals-grievances-tech-guidance.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023. Center for Medicaid and CHIP Services informational bulletin regarding "Medicaid and CHIP managed care monitoring and oversight tools. November 7, 2023. https://www.medicaid.gov/federal-policy-guidance/downloads/cib11072023.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022. Center for Medicaid and CHIP Services informational bulletin regarding "Medicaid and CHIP managed care monitoring and oversight tools." July 6, 2022. https://www.medicaid.gov/federal-policy-guidance/downloads/cib07062022.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021. Center for Medicaid and CHIP Services informational bulletin regarding "Medicaid and CHIP managed care monitoring and oversight tools." June 28, 2021. https://www.medicaid.gov/federal-policy-guidance/downloads/cib06282021.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. Medicaid Program; Medicaid and Children's Health Insurance (CHIP) Managed Care. Final Rule. *Federal Register* 85, no. 220: 72754-72844. https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016. Medicaid and Children's Health Insurance Program (CHIP) programs; Medicaid managed care, CHIP delivered in managed care, and revisions related to third party liability. Final rule. *Federal Register* 81, no. 88 (May 6): 27498–27901. https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

Florida Agency for Health Care Administration (AHCA). 2025. Florida Medicaid Statewide Medicaid Managed Care (SMMC) compliance actions dashboard. Tallahassee, FL: AHCA. https://bi.ahca.myflorida.com/t/ABICC/views/MedicaidManagedCare_15604365119380/ActionsTaken.

Indiana Family and Social Services Administration (FSSA). 2025. FFSA announces end of MDwise participation in Indiana Medicaid programs. Indianapolis, IN: FSSA. https://www.in.gov/fssa/files/MDwise-Participation_FINAL-2025.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2026a. Exhibit 30: Percentage of Medicaid enrollees in managed care by state and eligibility group. Washington, DC: MACPAC. https://www.macpac.gov/publication/percentage-of-medicaid-enrollees-in-managed-care-by-state-and-eligibility-group/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2026b. Exhibit 18: Distribution of Medicaid benefit spending by eligibility group and service category, FY 2023. Washington, DC: MACPAC. https://www.macpac.gov/publication/distribution-of-medicaid-benefit-spending-by-eligibility-group-and-service-category/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2025. *Report to Congress on Medicaid and CHIP.* March 2025. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2025/03/MACPAC_March-2025-WEB-Final-508.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2024. *Report to Congress on Medicaid and CHIP.* March 2024. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2024/03/MACPAC_March-2024-WEB-Final-508.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022. Understanding Medicaid managed care procurement practices across states. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2022/04/Understanding-Medicaid-Managed-Care-Procurement.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2013a. Table 17: Percentage of Medicaid enrollees in managed care by eligibility group, FY 2010. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2015/03/June-2013-MACStats.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2013b. Table 18: Percentage of Medicaid benefit spending on managed care by state and eligibility group, FY 2010. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2015/03/June-2013-MACStats.pdf.

National Association of Medicaid Directors (NAMD). 2024. *Why did they do it that way? Managed care.* Washington, DC: NAMD. https://medicaiddirectors.org/wp-content/uploads/2024/01/NAMD-Understanding-Medicaid-Managed-Care-01-18-24.pdf.

Office of the Inspector General (OIG), U.S. Department of Health and Human Services. 2020. *HHS-OIG Strategic Plan 2020–2025.* Washington, DC: OIG. https://oig.hhs.gov/documents/root/7/OIG-Strategic-Plan-2020-2025.pdf.

Ramakrishnan, A., and N.M. Tran. 2026. State sanctions may not affect Medicaid managed care. *American Journal of Managed Care* 32: no. 5. In press. https://cdn.sanity.io/files/0vv8moc6/ajmc/1e9a86a6e7ea6a5efc282ee14ff2293753a6da39.pdf/AJMC_05_2026_Ramakrishnan.pdf.

U.S. Government Accountability Office (GAO). 2024a. *Medicaid: Managed care plans' prior authorization decisions for children need additional oversight.* Washington, DC: GAO. https://www.gao.gov/assets/gao-24-106532.pdf.

U.S. Government Accountability Office (GAO). 2024b. *Medicaid managed care: Additional federal action needed to fully leverage new appeals and grievances data*. Report no. GAO-24-106627. Washington DC: GAO. https://www.gao.gov/assets/gao-24-106627.pdf.

Young, D. 2025. *Revisiting Medicaid managed care sanctions.* Washington, DC: National Health Law Program. https://healthlaw.org/resource/revisiting-managed-care-sanctions/.

Young, D. 2022. *Managed care sanctions: An important tool for accountability.* Washington, DC: National Health Law Program. https://healthlaw.org/wp-content/uploads/2022/12/Managed-Care-Sanctions_DY-updated-final.pdf.

Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on May 7, 2026.

State and Federal Tools for Ensuring Accountability of Medicaid Managed Care Plans

3.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to provide guidance on how to consistently report the types of accountability actions, such as liquidated damages, informal interventions, and other accountability actions taken in response to plan noncompliance, in the sanction section of the Managed Care Program Annual Report pursuant to 42 CFR 438.66(e)(2)(viii).

3.1 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McFadden, McCarthy, Nardone, Snyder
No	0	

3.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & 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.

3.2 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McFadden, McCarthy, Nardone, Snyder
No	0	

Chapter 4:

Addressing Appropriate Access to Residential Behavioral Health Treatment for Children in Medicaid

Addressing Appropriate Access to Residential Behavioral Health Treatment for Children in Medicaid

Recommendations

4.1 To ensure that states, families, and providers have complete, accurate, and up-to-date information about residential treatment facilities and bed availability, Congress should require that the Secretary of the U.S. Department of Health and Human Services (HHS) develop, maintain, and make publicly available a federally administered, up-to-date, real-time registry of youth residential treatment facilities serving Medicaid beneficiaries. The Secretary should work with HHS agencies, including the Centers for Medicare & Medicaid Services and the Substance Abuse and Mental Health Services Administration, state Medicaid agencies, state behavioral health agencies, and other stakeholders to develop and maintain this registry. The registry should include information on the behavioral health conditions facilities treat, ages served, real-time updates to bed availability for in- and out-of-state Medicaid beneficiaries, and accessibility of facilities and services for individuals with disabilities. The Secretary should leverage information already being collected by federal agencies and states, while also integrating other information needed to determine whether the facility can meet beneficiary need.

4.2 To ensure that reliable and consistently collected data are publicly available, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to regularly report on the use of residential treatment services by children and youth in Medicaid, including services provided by psychiatric residential treatment facilities (PRTF), non-PRTFs, and out-of-state residential treatment providers. This report should contain data on the characteristics of youth using the services including demographics, disability and co-occurring conditions, and urbanicity and rurality; types of services used; and average length of stay. The report should include data on the use of emergency departments for behavioral health needs, such as emergency department boarding by youth with Medicaid. If data are unavailable to report on key measures, CMS should develop a plan for collecting and publicly reporting on the data elements. CMS should engage states, providers, and other stakeholders in developing the data collection and reporting efforts.

4.3 To ensure that youth discharged from out-of-state residential treatment facilities return to their home states and communities and receive needed services, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend 42 CFR 441.155 to establish minimum requirements for discharge planning processes that mandate that the process involves all relevant actors including providers, plans, and families and caretakers. The requirements should mandate that the process involves identifying an appropriate community provider or alternative residential placement that has the capability and capacity to accept the beneficiary prior to discharge. CMS should also clarify what entities are responsible for initiating and overseeing the discharge planning process for an out-of-state beneficiary, and establish minimum requirements for coordinating and sharing information between the out-of-state provider and the post-discharge providers.

Addressing Appropriate Access to Residential Behavioral Health Treatment for Children in Medicaid

Key Points

- Medicaid supports a wide range of services for children and youth with complex behavioral health needs. These include residential treatment services, which are considered when medically appropriate.
- Federal law prohibits Medicaid payments for services provided to beneficiaries residing in an institution for mental diseases. However, there are several exceptions, including the "psych under 21" benefit. The benefit allows states to cover medically necessary services delivered in psychiatric residential treatment facilities, a psychiatric hospital, or a psychiatric unit of a general hospital to beneficiaries younger than age 21.
- The lack of easily attainable and specific information about the facilities serving Medicaid beneficiaries (e.g., bed availability and specialty area) makes it difficult for providers, beneficiaries, and caregivers to find residential treatment. States may seek out-of-state placement if an in-state placement cannot be identified.
- There is no single federal data source on the use of residential treatment by children enrolled in Medicaid, making it difficult to conduct a comprehensive analysis of their utilization of residential treatment services.
- Beneficiaries who are treated in residential treatment facilities, particularly out-of-state facilities, can experience challenges returning to their communities. Discharge planning can help with transitions from inpatient settings to community-based settings; however, current federal rules for discharge planning lack specificity.
- The Commission's recommendations address challenges that providers, families, and states face when identifying facilities with the capability and capacity to treat beneficiaries; the lack of publicly available, easily obtainable information on the use and users of residential treatment services; and the challenges that beneficiaries in a residential placement face in returning to their communities.
- MACPAC will continue to explore work that focuses on addressing the behavioral health needs of children enrolled in Medicaid with complex behavioral health needs across the continuum of care, including access to intensive community-based behavioral health services.

CHAPTER 4: Addressing Appropriate Access to Residential Behavioral Health Treatment for Children in Medicaid

The ongoing youth behavioral health crisis has been well documented, and research shows that children, including those with Medicaid, can face barriers to care in both community-based and residential treatment settings. For children whose needs cannot be met in the community, it is important that residential treatment options be available when they are needed. Medicaid supports a wide range of behavioral health services for children, including residential treatment programs when determined medically appropriate (MACPAC 2021).

Residential treatment services for children are clinical behavioral health interventions to treat individuals, including youth, with serious emotional disturbance (SED), serious mental illness (SMI), and substance use disorder (SUD).[1] Medicaid-enrolled children and youth typically access this intensive level of care in psychiatric residential treatment facilities (PRTFs), qualified residential treatment programs (QRTPs), or other settings. Prior analyses of Medicaid claims data have demonstrated that approximately 4.2 percent of Medicaid-enrolled children use residential treatment (Pires et al. 2018).[2] Studies in selected states have found that teens, males, and Black children are more likely to have disproportionately high uses of residential treatment (Rose and Lanier 2017, Wulczyn et al. 2015, Connor et al. 2004). In addition, youth involved in the child welfare system represent a small share of the Medicaid population but a disproportionate share of admissions to residential behavioral health treatment settings, including through custody relinquishment and the use of voluntary placement agreements (Hill 2017).

Children with behavioral health needs may be referred to residential treatment settings from several sources, ranging from providers to various child welfare agencies. Children may also be referred for residential treatment from emergency departments (EDs), mobile crisis response providers, urgent care, and home- and community-based service providers after a crisis or exacerbation in symptoms. In addition, in certain circumstances, courts may refer children who are involved in the child welfare system for placement in PRTFs or QRTPs if they have behavioral health needs that cannot be met in the community.[3]

As part of MACPAC's ongoing examination of children's access to behavioral health care, the Commission studied the factors affecting access to residential treatment for youth who need such services. The June 2025 report to Congress described Medicaid coverage of residential treatment services and the federal policies informing that coverage; the ways in which children may be referred for residential treatment, including in out-of-state facilities; and barriers to appropriate residential treatment. The Commission described both upstream and downstream effects on access to residential care when there is a lack of availability of home- and community-based behavioral health services; the challenges state Medicaid agencies, beneficiaries, and their families and providers experience in identifying treatment facilities with the capability and capacity to serve children in need of care; the lack of a nationwide data source to understand the use and users of residential behavioral health treatment; and the factors informing the use of out-of-state facilities.

Based on these findings, the Commission recommends:

4.1 To ensure that states, families, and providers have complete, accurate, and up-to-date information about residential treatment facilities and bed availability, Congress should require that the Secretary of the U.S. Department of Health and Human Services (HHS) develop, maintain, and make publicly available a federally administered, up-to-date, real-time registry of youth residential treatment facilities serving Medicaid beneficiaries. The Secretary should work with HHS agencies, including the Centers for Medicare & Medicaid Services and the Substance Abuse and Mental Health Services Administration, state Medicaid

agencies, state behavioral health agencies, and other stakeholders to develop and maintain this registry. The registry should include information on the behavioral health conditions facilities treat, ages served, real-time updates to bed availability for in- and out-of-state Medicaid beneficiaries, and accessibility of facilities and services for individuals with disabilities. The Secretary should leverage information already being collected by federal agencies and states, while also integrating other information needed to determine whether the facility can meet beneficiary need.

4.2 To ensure that reliable and consistently collected data are publicly available, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to regularly report on the use of residential treatment services by children and youth in Medicaid, including services provided by psychiatric residential treatment facilities (PRTF), non-PRTFs, and out-of-state residential treatment providers. This report should contain data on the characteristics of youth using the services including demographics, disability and co-occurring conditions, and urbanicity and rurality; types of services used; and average length of stay. The report should include data on the use of emergency departments for behavioral health needs, such as emergency department boarding by youth with Medicaid. If data are unavailable to report on key measures, CMS should develop a plan for collecting and publicly reporting on the data elements. CMS should engage states, providers, and other stakeholders in developing the data collection and reporting efforts.

4.3 To ensure that youth discharged from out-of-state residential treatment facilities return to their home states and communities and receive needed services, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend 42 CFR 441.155 to establish minimum requirements for discharge planning processes that mandate that the process involves all relevant actors including providers, plans, and families and caretakers. The requirements should mandate that the process involves identifying an appropriate community provider or alternative residential placement that has the capability and capacity to accept the beneficiary prior to discharge. CMS should also clarify what entities are responsible for initiating and overseeing the discharge planning process for an out-of-state beneficiary, and establish minimum requirements for coordinating and sharing information between the out-of-state provider and the post-discharge providers.

Building on the chapter in the June 2025 report to Congress, this chapter begins with a brief overview of access to residential treatment for Medicaid-enrolled youth, including the types of facilities available and the federal policies describing facility standards. The chapter then reviews the key findings from our work, highlighting the challenges families and providers face in locating appropriate placements for Medicaid-covered youth needing residential treatment, the limited publicly available data on the use and users of residential treatment facilities in Medicaid, and challenges youth in out-of-state placement face in returning to their communities. The chapter describes the Commission's policy recommendations for addressing these key challenges, their rationale, and the implications.

Background

Federal laws protect individuals, including children, from inappropriate use of institutional care, such as residential treatment facilities, and require state Medicaid agencies to ensure access to residential care for covered children who need it. The Americans with Disabilities Act of 1990 (ADA, P.L. 101-336) prohibits discrimination against individuals with disabilities, including Medicaid beneficiaries with SED and SMI, and requires that services such as necessary mental health treatment be provided in the most integrated setting appropriate. Under the U.S. Supreme Court's ruling in *Olmstead v. L.C.* (119 S. Ct. 2176 (1999)), states must provide treatment for individuals with disabilities, including SMI and SED, in community-based settings if the individuals do not oppose such services and if such placement is appropriate and can be reasonably accommodated by the state. Congress and the Centers for Medicare & Medicaid Services (CMS) have established key federal rules for Medicaid coverage of residential treatment services.

Early and Periodic Screening, Diagnostic, and Treatment

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement, consistent with Section 1905(r)(5) of the Social Security Act (the Act), entitles eligible Medicaid beneficiaries age 21 and younger to any treatment, including residential treatment, that is necessary to correct or ameliorate physical or mental conditions. Thus, children and youth with behavioral health needs have a statutory right to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in Section 1905(a) of the Act if that treatment is medically necessary. States have flexibility in how they meet their obligation to assess the availability of Section 1905(a) services for EPSDT-eligible youth.

Institutions for mental diseases

Federal Medicaid statute generally prohibits payments for services provided to beneficiaries residing in institutions for mental diseases (IMDs) (§ 1905(a)(30)(B) of the Act). An IMD is a "hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services" (§ 1905(i) of the Act). The IMD exclusion applies to facilities with more than 16 beds, including inpatient SUD and mental health treatment facilities as well as residential SUD and mental health programs (MACPAC 2019, CMS 2012). The definition encompasses several different types of facilities. The exclusion was designed to ensure that states and local governments retained their historical responsibility for funding inpatient psychiatric care (MACPAC 2019).

The "psych under 21" benefit is a federal statutory exemption to the IMD exclusion for children younger than age 21 (§§ 1905(a)(14), (16), (29)(B) of the Act).[4] States that have adopted this optional benefit can cover services delivered in a PRTF, a psychiatric hospital, or a psychiatric unit of a general hospital. Under the EPSDT requirement, all states must cover this optional benefit if an assessment determines that the level of service is medically necessary. If a state is unable to provide the psych under 21 benefit within its own borders, the state Medicaid program must cover the needed services in an out-of-state facility (CMS 2012).

Section 1115 demonstration authority also permits states to receive federal financial participation (FFP) for services provided to Medicaid beneficiaries with SMI or SED during short-term stays in psychiatric hospitals or residential treatment settings that are IMDs. States may also use the Section 1115 demonstration authority to receive FFP for services delivered to Title IV-E beneficiaries (i.e., children in foster care) in a QRTP that is an IMD (CMS 2019).[5] States must commit to improving connections to community-based care after stays in acute care settings, ensure a continuum of care is available to address the needs of beneficiaries with SMI or SED, provide a full array of crisis stabilization services, and promptly engage beneficiaries in treatment (CMS 2018).

Medicaid-enrolled children and youth typically access this intensive level of care in PRTFs, QRTPs, or other settings.

Facilities

Children with Medicaid in need of residential treatment services generally access residential treatment services in PRTFs and QRTPs.

PRTFs. PRTFs are non–hospital-based facilities that have an agreement with a state Medicaid agency to provide the psych under 21 benefit. Before admission to a PRTF, a youth's health care team certifies that community resources do not meet the treatment needs of the youth, treatment of the youth's psychiatric condition requires an inpatient level of care under the direction of a physician, and services can be reasonably expected to improve the youth's condition or prevent regression. Emergency admissions must be certified within 14 days of admission (42 CFR 441.152). The team must include a physician with competence in the diagnosis and treatment of mental illness (42 CFR 441.153). During their admission, a youth must receive active treatment specified in an individualized plan of care that must be reviewed at least every 30 days. The individualized plan of care must be based on a diagnostic evaluation, be developed by an interdisciplinary team of licensed mental health providers, include state treatment objectives, prescribe specific therapies and activities, and include post-discharge plans to ensure continuity of care with the youth's family, school, and community (42 CFR 141.154-156).

QRTPs. The Family First Prevention Services Act, enacted as part of the Bipartisan Budget Act of 2018 (P.L. 115-123), made substantial reforms to the child welfare system, including restricting the availability of Title IV-E foster care maintenance payments to 14 days unless the child is placed in a newly defined category of group homes called QRTPs.[6] QRTPs provide time-limited, trauma-informed treatment for children, including those in foster care with behavioral health disorders whose needs cannot be met in a family setting. Medicaid may reimburse for clinical, therapeutic, and rehabilitation services, depending on the state's Medicaid plan, if the QRTP is not an IMD (BBI 2019). Title IV-E may not reimburse the cost of any treatment services received by any child regardless of the child's Title IV-E eligibility. Title IV-E funds may reimburse QRTPs for maintenance costs, which include room and board, supervision, case management, and allocated indirect costs for children who are eligible. If a QRTP claims FFP for services under a 1915(i) state plan amendment, it must meet the home- and community-based service setting requirements (42 CFR 441.710(a)(1) and (2)).

QRTPs with more than 16 beds are likely to be subject to the IMD exclusion. FFP is available only if the facility complies with PRTF standards or the state uses a Section 1115 demonstration to deliver services to Title IV-E beneficiaries (i.e., children in foster care) in a QRTP that is an IMD (CMS 2019). An expert we spoke with noted that including QRTPs in Section 1115 demonstrations is administratively burdensome for states due to requirements for monitoring, reporting, and budget neutrality and that the length of stay limits previously approved by CMS are likely insufficient to treat youth who are eligible for QRTP placement. Federal QRTP rules allow 30 days to conduct an assessment to develop behavioral health treatment goals.

Number of facilities. In fiscal year (FY) 2026, there were 376 PRTFs in 36 states (CMS 2026). CMS reported that nationwide, the number of PRTFs declined from 372 in 34 states in FY 2021 to 344 in 34 states in FY 2023 before increasing in 2024 (360), 2025 (365), and 2026 (376) (CMS 2026).[7] Each state maintains a list of licensed QRTPs, but no publicly available database or repository includes, for example, the number of beds in each facility, the demographic and clinical profile of the children served by each facility, the total number of beds by state, or the number of children placed in out-of-state QRTPs under the Interstate Compact on the Placement of Children.[8]

Identifying Residential Treatment Facilities and Bed Availability

Families, providers, and state Medicaid agencies experience difficulty identifying residential treatment facilities with the expertise and capacity to treat children covered by Medicaid due to a lack of readily available, real-time, and comprehensive information. Missing information includes facility bed availability, specialty treatment areas, and populations served.

Facility treatment expertise and bed availability

Our research found that the difficulty in finding real-time information to identify facilities that can serve children and facility bed availability can hinder access to needed residential services (General Assembly 2022, Morrissette 2021, Virginia DBHDS 2021). Finding appropriate residential treatment options can be challenging for children with more complex needs, such as those with co-occurring intellectual and developmental disabilities (I/DD) or physical disabilities, SUD, sexualized behaviors, eating disorders, aggression, and more than one behavioral health diagnosis. Although the literature is limited, some research also finds that individuals with physical disabilities experience barriers to treatment, such as inaccessible treatment facilities and communication difficulties (Clemans-Cope and Lynch 2025). Other demographic characteristics of populations struggling to access appropriate residential care include age, location, language, sexual orientation, and race. In some cases, the lack of accessible residential treatment beds can lead to an out-of-state placement. Such placements can occur if in-state facilities lack the staff or expertise to address certain behavioral health conditions or if facilities decline an in-state placement in favor of an out-of-state placement because the latter provides higher payment than the former.

In our interviews, states expressed concern about their ability to readily discern the types of residential treatment facilities and their respective treatment modalities and expertise in out-of-state facilities when such care is needed. The process of finding a residential placement for a child who needs it can require families or providers to make multiple phone calls and can take from several hours to several days (Mark et al. 2019a). For example, the family of a child experiencing a behavioral health crisis or exacerbation of symptoms may seek treatment in an ED. If the child does not meet the medical necessity criteria for an acute hospital admission but requires intensive treatment, the ED may refer the youth for treatment in a residential facility. The ED staff must search, often by telephone, for an open bed at a facility that is capable of serving the child. This can be a laborious and lengthy process, and it can take days before staff can locate an appropriate placement and arrange safe, supervised transportation.

These longer-than-necessary stays in the ED, referred to as "ED boarding," increase stress for patients and delay needed behavioral health treatment that can mitigate the need for inpatient treatment. In addition, boarding consumes ED resources, worsens ED crowding, delays ED treatment for other patients who also have urgent needs, and includes financial repercussions for the ED (Morrissette 2021). ED boarding may cause patients to experience increased stress and delay mental health treatment that could mitigate the need for an inpatient stay (The Joint Commission 2021). Though longer-than-necessary stays in the ED can worsen patient stress and out-of-state placements may help with access to treatment, it can be difficult for states to monitor the care of beneficiaries placed out of state and for beneficiaries to maintain connections to their community in their home state.

There are some efforts to improve the availability of information on behavioral health providers, including residential treatment facilities. These efforts include federal and state databases or directories of facilities as well as state-operated registries of inpatient and residential treatment facilities.

Federal efforts

CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) operate databases that identify facilities providing behavioral health services; however, the databases are not designed to provide real-time information on bed availability. Bed registries are intended to provide such information, but a federal PRTF bed registry does not exist. Bed registries such as the hospital bed registry operated by the Centers for Disease Control and Prevention (CDC), though not a psychiatric bed registry, can provide insight into considerations for operating a real-time registry.

Databases of facilities providing behavioral health care. CMS and SAMHSA currently publish some limited information about facilities. CMS's Quality, Certification, and Oversight Reports website lists PRTFs and the findings from the required state-conducted health and safety surveys (Howard 2024).[9] States must provide CMS with information collected from PRTFs' annual attestation of compliance on the number of out-of-state youth served in the PRTF and a list of all states from which the PRTF has received payment for the psych under 21 benefit (CMS 2024). The website also provides information such as PRTF address, phone number, accreditation type, and ownership type but does not provide information about areas of expertise or treatment modalities. CMS does not independently verify the accuracy of the information from states (Howard 2024).

Congress directed SAMHSA to establish a searchable database of behavioral health providers, requiring that it include providers' names, locations, contact information, and services provided.[10] SAMHSA's FindTreatment.gov website allows users to search for behavioral health treatment facilities based on criteria such as location and acceptance of Medicaid, but it does not provide bed availability or identify whether facilities are PRTFs, QRTPs, or IMDs (SAMHSA 2025). FindTreatment.gov is updated annually from facility responses to SAMHSA's National Substance Use and Mental Health Services Survey (N-SUMHSS). SAMHSA adds new facilities meeting minimum requirements monthly while updating facility

names, addresses, telephone numbers, and services weekly for facilities informing the agency of changes (SAMHSA 2026).

SAMHSA implemented FindTreatment.gov in phases, which included planning and discovery (including an extensive gap analysis of information in existing substance abuse and behavioral health treatment locators), technical design requirements and considerations, database design and staging, and database launch. SAMHSA completed the design and implementation of the website in approximately 10 months. The agency regularly assesses the website and makes changes to improve its usability (e.g., with the user interface), addresses shortcomings, and keeps systems aligned with technological advances. A contractor implements the N-SUMHSS and is responsible for the quality of provider information before it is included on the website.

Key challenges in maintaining this database include ensuring that the provider information is accurate and clear and ensuring provider participation in the N-SUMHSS, which is used to populate the database. SAMHSA's user support team is responsible for addressing inaccuracies.[11] Securing provider participation in the survey is a challenge. SAMHSA's contractor conducts extensive state and provider engagement to improve the survey response rate and to reduce provider burden. For example, the contractor sends a prepopulated survey to providers who previously responded so that the providers have to update only the necessary information. SAMHSA does not have a dedicated team for maintaining the website and, given its complexity, draws on the expertise of officials across several components of the agency.

Non-behavioral health facility registries. CDC operates the Hospital Bed Capacity Project, which provides an example of a federally-administered bed registry. The Hospital Bed Capacity Project supports the automated, near–real-time collection of hospital bed capacity information to inform responses to public health emergencies and ensures the use of a standard definition of bed capacity by jurisdictions and hospitals (CDC 2026a).[12] Although the Hospital Bed Capacity Project is not specifically focused on behavioral health facilities, it offers insights into considerations for developing a national bed registry, including limitations and challenges.

Participation in the Hospital Bed Capacity Project is voluntary for states, the District of Columbia, and territories. Hospital participation is also voluntary, with acute-care and critical access hospitals, including federal hospitals and inpatient psychiatric facilities, eligible to participate (CDC 2026a).[13] Participating hospitals provide information, which is updated between every 15 minutes to an hour, on the number of occupied and unoccupied beds by bed type for each hospital (CDC 2026a).[14]

The CDC started the Hospital Bed Capacity Project in 2022 with a three-state pilot over 12 to 18 months, leveraging an existing platform for reporting hospital respiratory bed information, to test the feasibility of state collection and reporting of a standard set of bed availability data.[15] After the pilot, in December 2023, the CDC expanded the project and began recruiting additional states and territories to participate.[16] The CDC provided participating states and territories grant funding available for spending from January 2024 to July 2027 to support these efforts as well as ongoing technical assistance (CDC 2026c, Binder et al. 2025, Golshir and Sacht n.d.).[17] These jurisdictions lead the bed database reporting and are required to set up a governance committee to guide this work. For example, the governance committee determines how to approach the data collection, which vendors to engage, and who has access to the data and the level of that access. Due to the voluntary nature of reporting, participation levels vary, and some jurisdictions have experienced challenges with hospital engagement due to staffing constraints, technical requirements, and reporting burden.

State efforts

Some state agencies have developed and maintain online resources such as bed registries and searchable facility databases to help identify residential treatment options. State psychiatric bed registries vary in the type and completeness of information they make available, such as bed availability and treatment specialties of facilities. The Assistant Secretary for Planning and Evaluation (ASPE) at the U.S. Department of Health and Human Services (HHS) reported that in 2018, 17 states had bed tracking systems, and of those states, 5 made the information publicly available (Mark et al. 2019a).

To establish registries, some states have engaged stakeholders to guide the development, operation, and oversight of the registries (Michigan DHHS 2025, JLARC 2022).

In general, providers are responsible for entering bed availability information into a web-based platform, which authorized users can access to obtain bed availability. The frequency of updates varied among states from one to three times a day. Some states update registries in the morning and afternoon, while other states instruct hospitals to update registries once there is bed availability. The specificity of information reported also varies, with one state requiring hospitals to report on available staffed beds by sex for child, adult, and elderly patients.[18] ASPE also reported that facilities delegate responsibility for updating bed availability to a staff member such as an administrative professional, charge nurse, utilization manager, case manager, or social worker (Mark et al. 2019a).[19]

In 2023, North Carolina launched the Behavioral Health Statewide Central Availability Navigator that monitors daily bed availability in inpatient, residential, and other settings. The registry is available to clinical providers and staff at facilities, including EDs, inpatient psychiatric hospitals, and mobile crisis providers, that regularly interact with behavioral health beneficiaries who may be experiencing a crisis. The registry also allows providers and staff to search for an available bed based on demographics, acuity, commitment status, and location (North Carolina DHHS 2026). However, even with the bed registry, information on specialized care for sexualized behavior, autism spectrum disorder, co-occurring I/DD, and SUD is often unavailable (General Assembly 2022). Nonetheless, users of the state's registry describe it as helpful in identifying facilities that may be able to serve youth with residential treatment needs. Mississippi's Department of Mental Health maintains a psychiatric hospital bed registry that includes information on facility vacancies, scheduled admissions, whether individuals in different settings (e.g., jails, home) are awaiting a psychiatric bed, and the dates and times of the latest registry update (Mississippi DMH n.d.).

Several states have created publicly available dashboards to track bed availability. For example, Maryland's Department of Health Behavioral Health Administration created and maintains a crisis bed facilities dashboard that includes information about facility bed count and acceptance of referrals and walk-ins (Behavioral Health Administration 2026). Nebraska's Department of Health and Human Services develops and releases weekly regional bed capacity and wait time reports for two psychiatric facilities (Nebraska DHHS 2026a, 2026b). Virginia's Office of Children's Services hosts a web-based directory of providers that is intended to include contact information, real-time bed availability, and the type of patients being admitted in all public and private inpatient psychiatric facilities in the state (Virginia DBHDS 2021, 2020). However, in practice, the directory does not always include updated information on bed availability, types of residential settings, or residential facilities with particular specialties (JLARC 2022; Virginia DBHDS 2021, 2020). Kansas partnered with a community-based organization to develop and maintain the HealthSource Community Bed Board (HealthSource 2026).[20] This bed board provides the facility name and phone number, city and county, the category of services provided (e.g., inpatient psychiatric, sobering), and the ages served. The bed board also lists the number of available beds and color-codes facilities based on bed availability. Facilities that are color-coded green have available beds, while facilities that are color-coded red do not.

No nationwide studies have been published on the effect of psychiatric hospital bed registries on access to care; however, reports from users indicate that registries have improved access to residential treatment services and reduced wait times (JLARC 2022, Mark et al. 2019b, NRI 2017). Some states indicate that they can refer to information on a registry when engaging with hospitals, particularly when admission has been denied (Mark et al. 2019a). Users of a registry in one state reported that the registry improved access and helped to reduce ED wait times, although they did not have data to quantify the effects. These individuals also noted that psychiatric bed registries are helpful in identifying gaps in capacity (Mark et al. 2019a).

Bed registry design considerations and limitations

Establishing bed registries and facility databases is complex, and there are numerous design considerations. To implement bed registries, states have engaged stakeholders on these issues and conducted feasibility analyses to assess registry needs, objectives, and capability; examined implementation options (e.g., whether to use a phased approach); and identified funding (BerryDunn 2024, Maryland HSCRC 2022, Etherington 2021). In addition to providing complete, accurate, and real-time information, bed registries should be easy for care providers and seekers to use, provide information that can be filtered based on user-selected criteria, be interoperable with electronic health records, and provide data analysis and reporting capabilities (Virginia DBHDS 2020, Morrissette and Pinals 2018). Some stakeholders suggested that registries should also allow providers to reserve beds (Mark et al. 2019b).

States identified several limitations and challenges with bed registries, and some review their psychiatric bed registries to identify opportunities for improvements (Virginia DBHDS 2020, NRI 2018). Bed registries can help identify providers but do not necessarily eliminate the need for reaching out to facilities to confirm bed availability or treatment capabilities since the identification of an open bed in a facility does not guarantee placement (Massachusetts BHA 2026, Mark et al. 2019a, NRI 2018, HealthSource 2026). Some states that have implemented psychiatric bed registries have experienced difficulty securing hospital participation in the registry, which limits the registry's completeness and usefulness (Mark et al. 2019a; NRI 2018, 2017). Some providers and other clinical staff have expressed concern that the time spent on updating the registry impinges on time for patient care (Mark et al. 2019a).

Bed registries can be difficult to update in real time and are more likely to be periodically updated (JLARC 2022, APSE 2019, NRI 2018). Even so, the information can be used to connect individuals, including those already in facilities that are unable to provide the level of care needed, to facilities that can serve their needs (NRI 2017). Registry information can quickly become out of date as beds can be filled between the time one provider updates the registry and another provider checks it for bed availability (Mark et al. 2019a). Staff may have limited opportunities to update registries throughout the day (Mark et al. 2019b). Some states have taken steps to address the timeliness of registry updates by offering incentives such as expediting prior authorization processes for hospitals entering bed information, establishing performance metrics for timely updates, and monitoring the frequency of updates (Mark et al. 2019b). Challenges with outdated information are more likely to occur with registries that require manual data entry and may be mitigated with automated systems, which are less reliant on staff for updating bed information (Mark et al. 2019a). Finally, providers, many of whom are accustomed to identifying facilities and seeking bed availability by making telephone inquiries, may need training on using registries (Mark et al. 2019b).

Use of Residential Treatment

There are little publicly reported data on beneficiary use of residential treatment. Published research to assess utilization of residential treatment services by children enrolled in Medicaid, including those involved in the child welfare system, relies on disparate data sources and methodologies. For example, a 2018 analysis examining children's behavioral health services and expenditures from 2005 to 2011 found that roughly 4 percent of children age 0 to 18 had a claim for residential services (Pires et al. 2018). Another study of claims data found that in 2019, less than 0.1 percent of children age 3 to 17 who were enrolled in Medicaid with behavioral health conditions used residential treatment services (Radel et al. 2023).[21] A third study, using data from the National Survey on Drug Use and Health, found that in 2023, about 5 percent of non-institutionalized youth age 12 to 17 with Medicaid and Children's Health Insurance Program (CHIP) coverage received either residential services, had been hospitalized, or received other inpatient treatment for a mental health condition (SAMHSA 2024b).

Current data and reporting

No single federal data source systematically collects and analyzes the use of residential treatment by Medicaid-enrolled children age 0 to 21, which makes understanding their use of these services challenging (Lanier et al. 2024).[22] In addition, federal regulations do not require that states collect and report information on the use of residential treatment in settings other than PRTFs.

The CMS Transformed Medicaid Statistical Information System (T-MSIS) Behavioral Health Data Book provides numerous tables on Medicaid beneficiaries' use of behavioral health services, including mental health and SUD services across the continuum of care by state. In some cases, the data are reported separately for children and adults.[23] Specifically, the data book provides separate counts of child and adult beneficiaries receiving treatment for behavioral health and for co-occurring mental health and SUD. However, much of the reported data, including the use of residential treatment care services, readmissions, and the use of the ED after discharge, are not disaggregated by age. The data book reports service use by setting, including residential setting; however, the definition of residential setting includes a number of settings such as long-term care hospitals and assisted living facilities (CMS 2025). In addition, the data book does not differentiate between different types of residential facilities, including IMDs, or whether services are provided to in- or out-of-state children. Disaggregating data by beneficiary type (adult or child) and residential facility type (PRTF, QRTP, or other congregate care facility) would help states and policymakers understand who uses the services, the utilization, and the types of facilities treating children. The data book does not provide information on child beneficiary use of out-of-state services or the number of out-of-state youth that states serve.

Data limitations make conducting a comprehensive claims analysis of residential treatment services by youth difficult. PRTFs are assigned a specific place of service code, making it easier to identify claims associated with this provider type. Identifying QRTPs and other residential provider types is challenging, as those provider types may or may not have a specific place of service code assigned by their respective state Medicaid agency. Without specific place of service codes, it is difficult to differentiate claims submitted for clinical, therapeutic, or rehabilitative services delivered in an institution that is not an IMD from those delivered in office-based settings. An analysis of PRTF-only claims would likely be of limited generalizability as youth also receive residential treatment in non-PRTF settings (Brown et al. 2010).

Most states in our study collect some information about denials of admission, such as the reason for denial. Among the states in our study, the most common reasons for denied admission in residential treatment facilities included the beneficiary's older age; having current or previous child welfare or juvenile justice involvement; having a history of aggressive or sexualized behaviors or elopement; and having co-occurring conditions, including SUD, I/DD, or autism. In some cases, these characteristics may be a factor in a beneficiary's need for a residential level of care. Some PRTFs may also deny admission due to co-occurring medical conditions. Denials of admission could lead to delays in getting the care that is needed, prolonged ED boarding, and the need for placement in an out-of-state facility.

Existing CMS data collection may also be helpful in describing youth utilization of residential treatment services and may provide a foundation for more robust reporting. CMS collects limited information from states through the PRTF certification process, but CMS does not validate or publish it. Specifically, states must provide CMS with information collected from PRTFs' annual attestation of compliance on the number of out-of-state youth served in the PRTF and a list of all states from which the PRTF has received payment for the psych under 21 benefit (CMS 2024). In addition, CMS will collect data from hospitals on ED boarding of children and adults beginning with voluntary reporting for the calendar year 2027 reporting period and mandatory reporting beginning with the calendar year 2028 reporting period. CMS plans to make the data public.[24]

Out-of-State Placements

Out-of-state placements may be necessary if in-state facilities lack the capacity or expertise to address the behavioral health needs of youth referred for treatment or if they otherwise deny admission. Out-of-state placements can help ensure access to needed residential treatment; however, youth in these facilities can experience challenges maintaining ties to their families and communities.

Use of out-of-state placements

When families, providers, and states are unable to find treatment and services in a child's community, they broaden their search for options, which can include out-of-state treatment facilities.[25] For example, in-state PRTFs may deny admission due to a child's diagnosis or functional or behavioral health characteristics or to reserve beds for out-of-state patients to secure higher payment rates. Securing appropriate residential treatment options can be challenging for some children and youth, such as those with more complex needs or certain demographic characteristics (e.g., age, language needs) (MACPAC 2025a). In addition, states with large rural or frontier areas reported difficulty in maintaining access for all youth in their state and may seek out-of-state placement for beneficiaries.[26]

National-level data on the use of out-of-state placement in residential treatment facilities are not publicly reported. However, certain state-level data indicate that in some states, out-of-state placements have increased in recent years. For example, the number of Montana children placed in out-of-state PRTFs increased from 174 in state fiscal year (SFY) 2023 to 198 in SFY 2024 (Montana DPHHS 2024). Similarly, Montana's out-of-state placement report for SFY 2024 showed the overall number of children who received residential treatment in PRTFs and other facilities outside the state increased from 239 in SFY 2023 to 254 in SFY 2024.[27] In addition, the most common diagnoses for Montanan youth with a Medicaid-funded out-of-state placement were disruptive and impulse control behaviors (32.1 percent), depressive disorders (29.1 percent), trauma and stress disorders (19.4 percent), and autism spectrum disorders (8.9 percent) (Montana DPHHS 2024).[28] In North Carolina, of the children placed in PRTFs, the percentage placed out of state increased from 27 percent in 2016 to 44 percent in 2022 (Lanier et al. 2024, General Assembly 2022). Another state included in our study indicated that it makes few out-of-state placements but that there has been an increase in children coming from out of the state for residential treatment services.

States typically make multiple attempts to find an appropriate in-state residential setting before making an out-of-state PRTF placement to provide the psych under 21 benefit. For example, a Medicaid official in one state reported having to make between 40 and 60 referrals to facilities before being able to find a placement, and some facilities do not provide timely responses about denials or acceptances. Some states are working to minimize out-of-state placements and focus resources on keeping children in state. Montana tries to place children in the lowest level of care in state and requires denials from two in-state PRTFs before it places children out of state (Montana DPHHS 2024). North Carolina officials reported working with facilities to create specialized placements to keep children in state, but the parents and guardians may still decide to send children out of state.

Returning to the Community

Stays in residential treatment facilities are intended to be short term, with the goal of returning the patient to community-based care as quickly as is medically appropriate. Our research found that beneficiaries being served in residential treatment facilities, whether in or out of state, can face barriers to returning to their communities and community-based care.

Delayed discharge

Some beneficiaries may experience delayed discharge, in which they remain in a facility even after a clinical team deems that the level of care is no longer necessary because the family, provider, or state is unable to find appropriate community-based care (Eldeib 2020). Delayed discharge from inpatient psychiatric hospitals, EDs, and hospitals is well documented, but there is little literature about this phenomenon when patients leave PRTFs, which are

non-hospital facilities (Teale et al. 2024, Illinois DCFS 2023, Eldeib 2020, PCG 2018).[29] However, hospitals, EDs, and PRTFs are likely to face similar challenges securing community-based behavioral health services for patients who can be transitioned out of the facilities. Examples of factors contributing to delayed discharge include limited or no available providers in the community, family concerns about the transition, lack of support with the transition, and insufficient discharge planning (Minnesota DOH 2024, Teale et al. 2024, Micallef et al. 2020, LAC 2019, MHA 2019, PCG 2018).

Delayed discharge can lead to deterioration of the youth's condition, unnecessary costs for the Medicaid program, and additional challenges when reintegrating back into their home communities (MACPAC 2025b, Abdelhalim et al. 2024, AHA 2022). In addition, delayed discharge can limit the ability of facilities to admit and treat other youth awaiting residential placement (Teale et al. 2024, Micallef et al. 2020, PCG 2018). Youth who are discharged to temporary or inappropriate placements and experience discontinuity of care are at risk of readmission, which may strain limited residential bed capacity (PCG 2018). Examples of interventions to help with timely discharge from hospital inpatient behavioral health settings or EDs include the use of discharge coordinators (e.g., a single clinician or a team) and the use of electronic health record integrated tracking tools, which can help improve the discharge process and reduce the length of stay (Bechir and Bechir 2025, Ibrahim et al. 2022, Houghton et al. 1996).

Discharge from out-of-state placement

Some state Medicaid officials reported that out-of-state placements can make it difficult for children and youth to maintain connections with family and transition back to their respective states of residence. Federal rules are in place to ensure that the needs of youth can be met and to mitigate gaps in care while the youth are in residential treatment facilities and on discharge. However, these rules do not specifically address circumstances in which a beneficiary is placed in an out-of-state facility. Discharge planning is further complicated when a youth has been placed out of state. The distance between the youth and their family may make it difficult for caregivers to engage in treatment, treatment planning, and care coordination to reintegrate the youth into their home, community, and school (MACPAC 2025b). Caregiver engagement is associated with positive treatment outcomes during and after treatment (Haine-Schlagel and Walsh 2015).

The lack of an adequate discharge plan that identifies where youth will be treated on discharge from the facility, including out-of-state locations, contributes to the transition challenges families and providers of youth in residential treatment facilities face (MACPAC 2025b). Some youth in out-of-state facilities may experience particular challenges with returning to their communities if, for example, the receiving PRTF is unable to adequately treat them due to the complexity of their needs or because their condition decompensates to the point of needing a higher level of care that the facility cannot provide. Some of these youth may present in hospital EDs in the receiving state that do not have a provider agreement with the sending state, and the responsibility for the care of the youth may be unclear. In some cases, youth may return home, although the lack of services in the community persists (CRD 2022). In Maine, in the past, some children in foster care with behavioral health needs were discharged from hospitals and residential treatment to hotels and homeless shelters because the state's Office of Child and Family Services could not secure homes for their long-term care, placing them at risk of reinstitutionalization (PCG 2018).[30]

Discharge planning

Discharge planning can help with transitions from inpatient settings to other health care settings, including community-based providers (Tyler et al. 2021, Xiao et al. 2019, Smith et al. 2017). Discharge planning can help ensure continuity of care, connect discharged individuals to appointments after discharge, and reduce readmissions (Smith et al. 2022). Several elements comprise discharge planning, such as the identification of post-discharge treatment needs and providers, communication among inpatient and outpatient providers and patients or their caregivers to establish post-discharge treatment plans and preferences, scheduling of appointments, and transmittal of necessary medical records (Smith et al. 2022, Xiao et al. 2019, Smith et al. 2017). The American Academy of Child and Adolescent

Psychiatry (AACAP) principles for the treatment of children and adolescents with mental illnesses in residential treatment centers identifies the return of admitted youth to the community as a central goal of residential treatment and describes discharge planning as a key component of treatment plans. AACAP calls for discharge planning that begins on admission to a residential treatment facility, ensures that children have a provider to go to for care on discharge, and coordinates with community-based providers (AACAP 2010). Although discharge planning is generally considered a standard of care for patients leaving inpatient settings, researchers have noted the need for additional research to understand how it is implemented and its effects on transitions between care settings (Smith et al. 2017).

Federal regulations for the plan of care developed for beneficiaries admitted to PRTFs describe requirements for discharge planning, but the requirements lack specificity. Federal regulations require that a physician develop a written plan of care for each beneficiary before admission and that it is entered into the beneficiary's record and reviewed every 30 days (42 CFR 441.155(a), 42 CFR 441.155(c)). The plan of care must include plans for discharge when appropriate and post-discharge plans that include coordination with other inpatient services and community-based services on release (42 CFR 456.180, 42 CFR 441.155(b)(5)). Federal rules do not further address PRTF discharge planning or the contents of discharge plans.

CMS has highlighted the importance of beneficiaries returning to their communities on discharge from a facility in the context of other CMS programs and discharge planning. For example, CMS's guidance to states for coordinating care provided by out-of-state providers for children in Section 1945A health homes emphasized the importance of maintaining connections to the community and facilitating seamless returns after a stint in out-of-state care (CMS 2021).[31] In addition, Medicare rules include detailed conditions of participation related to hospital discharge planning (42 CFR 482.43). The rules describe requirements for the hospital discharge planning process (e.g., timeliness, assistance for families in selecting post-discharge providers), the transfer of the patient's medical information to post-discharge providers, and a discharge planning evaluation for individuals who are likely to suffer adverse health consequences on discharge if no such plan is established (CMS 2023). CMS requires timely discharge planning evaluations to do the following:

- ensure that care arrangements are made before discharge to prevent unnecessary delays in discharge;
- evaluate the need for appropriate post-discharge services, including non-health services and community-based care providers, and the availability of the services;
- be included in the patient's medical record and be discussed with the patient or the patient's representative;
- ensure that hospitals arrange for the development and implementation of discharge plans upon a physician's request;
- be developed by or under the supervision of a registered nurse, social worker, or other appropriately qualified personnel; and
- regularly reevaluate the individual's condition to determine if changes to discharge plans are needed.

The rules also require that hospitals reassess their discharge planning processes regularly, including reviewing a sample of discharge plans, and that hospitals assist patients in selecting a post-acute care provider and share data on quality measures relevant to the patient's goals of care and treatment preferences (42 CFR 482.43).[32]

Some state Medicaid programs have publicly posted PRTF discharge policies and state discharge plan requirements, which vary state to state. For example, West Virginia's guidance for PRTF discharge planning dictates that the discharge plan identifies the planned and actual discharge date, the name of the person or entity expected to take responsibility for care and custody, and the address of where the beneficiary is expected to live on discharge. The state also requires the PRTF to provide a written copy of an aftercare plan, a supply of current prescription medication, and documentation of communication

between the facility and community psychiatrist (West Virginia DHHR 2013).[33] Montana's discharge planning guidance specifies that PRTFs must identify prescribing providers in the community and schedule an outpatient visit (Montana DPHHS 2023). One study of state regulations and policies for state residential treatment of behavioral health conditions for adults found that treatment planning and discharge planning requirements are more likely to be a function of licensure standards than they are state Medicaid regulations (O'Brien et al. 2021).

Commission Recommendations

The Commission makes three recommendations to Congress to improve appropriate access to residential behavioral health treatment for children and youth enrolled in Medicaid.

Recommendation 4.1

To ensure that states, families, and providers have complete, accurate, and up-to-date information about residential treatment facilities and bed availability, Congress should require that the Secretary of the U.S. Department of Health and Human Services (HHS) develop, maintain, and make publicly available a federally administered, up-to-date, real-time registry of youth residential treatment facilities serving Medicaid beneficiaries. The Secretary should work with HHS agencies, including the Centers for Medicare & Medicaid Services and the Substance Abuse and Mental Health Services Administration, state Medicaid agencies, state behavioral health agencies, and other stakeholders to develop and maintain this registry. The registry should include information on the behavioral health conditions facilities treat, ages served, real-time updates to bed availability for in- and out-of-state Medicaid beneficiaries, and accessibility of facilities and services for individuals with disabilities. The Secretary should leverage information already being collected by federal agencies and states, while also integrating other information needed to determine whether the facility can meet beneficiary need.

Rationale

This recommendation addresses the challenges that states, providers, and families face in identifying residential treatment facility options with the capability and capacity to serve youth with Medicaid by having HHS lead and coordinate efforts to develop and maintain a registry of facilities.

This registry is needed because there is no single source of information to help states, families, and providers identify Medicaid-serving residential treatment facilities, the conditions they treat, and bed availability, which can lead to delays in services for youth needing such care. The process of finding a residential placement for a child who requires it can take several hours to several days, which, in the case of children in crisis in an ED, can lead to ED overstays. It can be especially difficult to find appropriate treatment options for certain children with complex needs or co-occurring conditions. Some states said that finding placement for youth with certain characteristics, such as being a younger age or having a rural residence, can be harder than it is for other children.

There is no federal requirement that states or CMS maintain a real-time registry of psychiatric residential treatment providers. Despite the lack of a federal mandate, the federal government and states already collect and make available some facility information. State efforts include databases and registries, which vary in their scope and requirements. No current source provides the full complement of real-time information needed to identify residential treatment options when such care is needed. For example, one state's system provides information on inpatient and residential bed availability, while another's identifies facilities but does not include bed availability. In general, users of the state registries describe them as helpful in identifying facilities that may be able to serve youth with residential treatment needs. Given the role of out-of-state providers in serving Medicaid youth, a centralized registry would help to ensure that information is consistently reported and mitigate users having to find and navigate multiple directories or registries.

Although CMS's QCOR website has basic information about PRTFs, and SAMHSA's FindTreatment.gov website identifies providers of behavioral health services nationwide, the agencies' facility databases are not intended to provide real-time bed availability and do not provide key aspects of information needed to determine whether facilities can meet beneficiary need. CMS's QCOR website is primarily intended to provide information about facilities' recent certification and quality survey results. It does not provide information such as treatment expertise or bed availability. SAMHSA's database is searchable and includes the names, locations, contact information, services provided, and accepted insurance of the providers who choose to respond to the survey, which collects facility information. It does not identify whether facilities are PRTFs or QRTPs.

The Commission weighed the complexity of developing and operating a national registry with the needs of children who have intense behavioral health conditions that cannot be met in the community and the challenges faced by families, providers, and states in finding appropriate residential treatment options. Our research shows that there is a lack of readily available and complete information needed to help families find residential treatment options for youth when they most need it. Delays in accessing medically necessary residential treatment can harm youth and burden caregivers, providers, and states. Operationalizing a national registry will be challenging and will require careful examination of numerous policy and operational considerations and thoughtful and deliberate planning.

In developing the registry, the Secretary should leverage information that is already collected and the experience of agencies operating facility databases and registries. It will be important that the process to develop and maintain the facility registry minimizes duplication and burden on providers, states, and federal agencies. HHS should also engage stakeholders to ensure that the registry will meet user needs while minimizing facility reporting burden. Stakeholders include federal partners with responsibility for behavioral health and experience with facility registries such as SAMHSA and the CDC, state Medicaid agencies, beneficiaries and their representatives, hospitals, managed care plans, crisis services experts, community-based providers, information technology systems experts, and law enforcement officials. HHS should seek input on all aspects of registry development, including, for example, technical specifications for the registry, applicability of the registry (e.g., which facilities should report), reporting parameters (e.g., frequency of reporting, whether providing reporting is mandatory or voluntary), developing documentation and guidance for submitting and using information from the registry, and establishing monitoring and oversight of the development and use of the registry. Stakeholders may also be a helpful resource for identifying and developing approaches to address challenges that may arise in the development and maintenance of the registry (e.g., provider participation).

Implications

Federal spending. The Congressional Budget Office (CBO) estimates this recommendation would not affect federal direct spending. HHS will need to commit time and personnel for the development, implementation, and maintenance of the registry; create guidance for the use of the registry; and monitor registry use and facility participation.

States. State Medicaid agencies and providers may experience costs associated with investing in technology and infrastructure to support a real-time registry. Depending on how the registry is structured, states could be responsible for certain functions, such as ones to encourage the use of the registry and timely provider updates. States will experience greater ease in identifying facilities with available beds that may be able to serve Medicaid beneficiaries compared to current practices.

Enrollees. Beneficiaries and their families and caregivers may experience greater ease in identifying facilities with available beds that may be able to serve them or their loved ones compared to current practices.

Plans. Plans may experience greater ease in identifying facilities with available beds that may be able to serve Medicaid beneficiaries compared to current practices.

Providers. Providers may experience greater ease in identifying facilities with available beds that may be able to serve Medicaid beneficiaries compared to current practices. Facilities may be required to update the bed registry according to specifications for bed availability updates, which will add to their administrative burden.

Recommendation 4.2

To ensure that reliable and consistently collected data are publicly available, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to regularly report on the use of residential treatment services by children and youth in Medicaid, including services provided by psychiatric residential treatment facilities (PRTF), non-PRTFs, and out-of-state residential treatment providers. This report should contain data on the characteristics of youth using the services including demographics, disability and co-occurring conditions, and urbanicity and rurality; types of services used; and average length of stay. The report should include data on the use of emergency departments for behavioral health needs, such as emergency department boarding by youth with Medicaid. If data are unavailable to report on key measures, CMS should develop a plan for collecting and publicly reporting on the data elements. CMS should engage states, providers, and other stakeholders in developing the data collection and reporting efforts.

Rationale

The lack of consistently collected and reported data impedes a systematic analysis of the use of residential treatment services. Such an analysis would be helpful for understanding trends in service use, such as which services are most frequently used and by whom, geographic differences in residential treatment use, trends in out-of-state facility use, differences in service use by beneficiary demographic characteristics, overstays in the ED, and characteristics of beneficiaries experiencing overstay. Understanding trends on these and other measures would be helpful in detecting whether there are access challenges to certain services, in certain states, or for particular subgroups of beneficiaries. Greater reporting of data on the use of residential treatment services may also be helpful for improving our understanding of which Medicaid beneficiaries are referred to, admitted to, denied admission to, and discharged from residential treatment facilities. A data reporting and collection approach will help fill current knowledge gaps and strengthen the ability of CMS, states, and stakeholders to make data-informed decisions about policy and programmatic changes to address access concerns.

Federal regulations do not require that CMS or states collect and report information on the use of residential treatment in settings other than PRTFs for children covered by Medicaid and CHIP. Because beneficiaries may be served in settings other than PRTFs, an analysis of PRTF claims only would underestimate the use of residential treatment services. Similarly, there are no federal requirements for state reporting on the use of out-of-state residential treatment providers by Medicaid beneficiaries.

Congress has previously contemplated the need for data on the use of out-of-state providers to serve children with medically complex conditions. Specifically, in creating the 1945A health home state plan option for children with medical complexity, Congress required states to describe in their state plans their methodology for tracking access to medically necessary care from out-of-state providers (§ 1945A(f)) and to report to the Secretary on the number of characteristics of providers, including out-of-state providers, serving children under the health home option (§ 1945A(g)(2)(A)).

CMS already collects data that may be helpful in shedding some light on youth utilization of residential treatment services. For example, CMS collects some information from states through the PRTF certification process, but that information is limited, and CMS does not validate or publish it. In addition, CMS's behavioral health T-MSIS data book lacks detail for understanding the experience of youth in Medicaid, does not differentiate among different types of residential facilities, and does not describe use of out-of-state facilities. States collect some data for their own programmatic purposes, which can be helpful for identifying in-state trends, but those data lack comparability across states. Disaggregating data by age (i.e., for adults and children) and residential facility type (e.g., PRTF, QRTP, or other congregate care facility) would help states and policymakers that want to understand the frequency of children receiving

residential treatment services and the types of facilities children are commonly sent to for treatment. The data collection and reporting effort for CMS's new hospital Emergency Care Access and Timeliness electronic clinical quality measure may also be an important source of information on ED boarding for youth awaiting residential treatment.

To the greatest extent possible and to minimize burden, CMS should leverage data that are already collected and existing reporting mechanisms. Some residential treatment services data are not currently readily available and may require CMS to develop a plan for working with states and other stakeholders to collect them. For example, certain facilities, such as QRTPs, do not have a specific place of service code for claims and may be difficult to identify in the administrative data. Additionally, some measures that are not regularly reported may require an assessment of data availability and quality and feasibility of reporting (e.g., average length of stay). CMS should develop and publicly share a plan for assessing additional data needs, collecting those data, and publishing findings. CMS should engage states, providers, and other stakeholders in developing the data collection and reporting efforts. To establish this data reporting effort, CMS should engage states and other stakeholders on data elements that should be collected and reported and opportunities to leverage existing data collection mechanisms.

Implications

Federal spending. The CBO estimates this recommendation would increase federal direct spending by less than $10 million over the 2026 to 2036 period.

States. Some states may have to take on additional data collection and reporting, if they do not already collect data that would be newly required as a result of implementing this recommendation. They may also experience some costs associated with systems changes needed for transmitting data to CMS. States may benefit from having newly available information on the use of residential treatment services.

Enrollees. Beneficiaries, families, and caregivers may have an improved understanding of trends in residential treatment service use.

Plans. Plans may have an improved understanding of trends in residential treatment service use.

Providers. Providers of residential treatment services may experience some burden and resource expenditures (e.g., related to systems changes, staff time) to fulfill new reporting requirements. Providers may have an improved understanding of trends in residential treatment service use.

Recommendation 4.3

To ensure that youth discharged from out-of-state residential treatment facilities return to their home states and communities and receive needed services, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend 42 CFR 441.155 to establish minimum requirements for discharge planning processes that mandate that the process involves all relevant actors including providers, plans, and families and caretakers. The requirements should mandate that the process involves identifying an appropriate community provider or alternative residential placement that has the capability and capacity to accept the beneficiary prior to discharge. CMS should also clarify what entities are responsible for initiating and overseeing the discharge planning process for an out-of-state beneficiary, and establish minimum requirements for coordinating and sharing information between the out-of-state provider and the post-discharge providers.

Rationale

Treatment in psychiatric residential facilities for beneficiaries who require that level of care is intended to be short term with the goal of transitioning beneficiaries back into their communities or states, in the case of those in out-of-state facilities. However, beneficiaries, in particular those in out-of-state placement, experience challenges related to discharge and returning to their communities. For example, children sent out of state may face challenges maintaining connections with their families and caregivers who are integral to their post-discharge care. In some instances, children are ready to be discharged, but providers and families experience challenges with identifying an adequate provider in the youth's community, which can lead to delayed discharge.

Discharge planning processes are important for documenting a plan for transitioning individuals from inpatient care to community-based care and can help ensure discharged individuals are connected to providers and services once they leave the facility. For example, discharge plans can describe requirements and processes for identifying post-discharge treatment needs and providers, communicating between inpatient and outpatient providers and patients or their caregivers to establish post-discharge treatment plans and preferences, scheduling appointments, and transmitting necessary medical records. Discharge planning is generally considered the standard of care. AACAP calls for discharge planning that ensures that children have a provider on discharge who coordinates with community-based providers (AACAP 2010).

There are few federal Medicaid requirements for discharge planning from PRTFs. In contrast, Medicare hospital discharge rules are detailed and include several specific discharge planning requirements to ensure beneficiaries return to their communities. Similarly, some states have implemented PRTF discharge planning requirements.

To ensure that expectations are clear for facilities, providers, beneficiaries, families, and caregivers, this recommendation would ensure that discharge plans thoroughly and clearly identify which entities are responsible for PRTF discharge planning processes and actions and require that a specific community-based provider be identified before discharge. This recommendation would also require the involvement of those who would be involved in the beneficiary's post-discharge care, including families and caregivers. In implementing this recommendation, CMS should engage stakeholders, including families, providers, and states, to identify other required elements for PRTF discharge planning, which may include, for example, which clinicians and professionals should be involved in discharge planning, updates to discharge plans, and monitoring and oversight of discharge plan implementation.

Implications

Federal spending. The CBO estimates this recommendation would increase federal direct spending by less than $10 million over the 2026 to 2036 period.

States. States may need to update discharge policies based on new federal requirements and may need to develop and disseminate guidance to plans and providers. States may need to engage in oversight and monitoring to ensure discharge plans satisfy requirements and to ensure the fidelity of implementation.

Enrollees. Beneficiaries in out-of-state placement and their families and caregivers will have a clearer understanding of how discharge plans should be developed. Beneficiaries may also experience improved transitions back to their communities, including being connected with local providers capable of meeting their needs.

Plans. Plans would need to establish guidance for providers regarding expectations for discharge planning and coordinating a return to the community for youth placed in out-of-state facilities. Plans would also gain information about the ongoing treatment needs of covered youth in out-of-state facilities, which should help with care management efforts.

Providers. Providers may need to implement new discharge planning processes and activities, which may take longer to conduct than current approaches. Post-discharge providers will have information about the health care needs of youth coming into their care from out-of-state facilities.

Looking Ahead

These recommendations are intended to help with appropriate access to residential behavioral health treatments for youth with Medicaid coverage who require that level of care. Residential treatment, while a last resort, is an important part of the continuum of behavioral health care. To fully meet the behavioral health needs of children and youth with Medicaid coverage, the continuum must also include myriad community-based services. In future work, MACPAC will examine access to intensive community-based behavioral health services as well as quality of care and safety within residential treatment facilities.

Endnotes

[1] SED describes a child who has a diagnosable mental, behavioral, or emotional disorder (e.g., bipolar disorder and schizophrenia) that substantially interferes with their life and ability to function (SAMHSA 2024a). SMI describes a diagnosable mental, behavioral, or emotional disorder (e.g., bipolar disorder and schizophrenia) experienced by someone older than age 18 that substantially interferes with their life and ability to function (SAMHSA 2024a).

[2] The authors defined residential treatment as "mental health and/or substance use treatment in a licensed, highly structured, usually secure out-of-home program providing continuous 24-hour observation and supervision with typically a full complement of in-house programs including education." The authors described therapeutic group homes as providing "24-hour out-of-home mental health and/or substance use services in a licensed, non-secure facility, with children typically involved in community-based activities, such as school, work, or recreation" (Pires et al. 2018).

[3] Such placements may occur if the child welfare agency files a petition with the court for an out-of-home placement order after substantiating abuse or neglect and a finding of imminent harm or after prevention services and supports have been deemed unsuccessful. The court may place the child with kin or in foster care or therapeutic foster care as well as in a QRTP, PRTF, or other congregate care setting, depending on the child's needs. Section 473(b)(1) of the Social Security Act (the Act) requires that Title IV-E eligible youth be considered to be receiving cash assistance. Section 1902(a)(10)(A)(i)(I) of the Act makes those cash assistance recipients eligible for Medicaid (42 CFR 435.145).

[4] Section 1012 of the SUPPORT Act (the SUPPORT Act, P.L. 115-271) also created a limited exception to the IMD exclusion for certain women who are eligible for Medicaid on the basis of pregnancy. Specifically, it prohibits states from denying FFP for non-IMD services delivered to pregnant women (and up to 60 days postpartum) that are patients of an IMD for the treatment of an SUD. Typically, FFP is not available for services delivered outside of an IMD if an individual is a patient of an IMD (MACPAC 2019).

[5] Title IV-E of the Act provides federal funding for child welfare assistance to low-income children who have been removed from their homes. Children receiving assistance under Title IV-E are automatically eligible for Medicaid.

[6] The term "foster care maintenance payments" means payments to cover the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, reasonable travel to the child's home for visitation, and reasonable travel for the child to remain in the school in which the child is enrolled at the time of placement. In the case of institutional care, such term shall include the reasonable costs of administration and operation of such institution as are necessarily required to provide the items described in the preceding sentence (P.L. 115-123).

[7] The count of PRTFs refers to the number of such providers for which CMS has survey records in the agency's online survey and certification reporting system.

[8] The Interstate Compact on the Placement of Children is a statutory agreement between all 50 states, the District of Columbia, and the U.S. Virgin Islands. The agreement governs the placement of children in the custody of a state who are being placed for private or independent adoption or, under certain circumstances, being placed by a parent or guardian in a residential treatment facility from one state into another state (APHSA n.d.).

[9] The website pulls data from the Automated Survey Process Environment and certification reporting system used by state survey agencies to document their required health and safety surveys of PRTFs.

[10] The 21st Century Cures Act (P.L. 114-255) required that SAMHSA develop and maintain an online, searchable behavioral health treatment services locator (OIG 2025). SAMHSA also makes available a written directory of the facilities that are included on the SAMHSA's FindTreatment.gov website. The providers listed on the website and in the directory are public and private providers of behavioral health services that responded to the National Substance Use and Mental Health Services Survey (SAMHSA 2024b).

[11] In a March 2025 report, the U.S. Department of Health and Human Services Office of the Inspector General described finding inaccurate or incomplete information (e.g., addresses, facility treatment approaches) for several facilities, but SAMHSA has since addressed these concerns (OIG 2025).

[12] The Hospital Bed Capacity Project is implemented through the CDC's National Healthcare Safety Network (NHSN). The data collected under the initiative are intended to help with the coordination and response to emergencies.

The NHSN is a tracking and response system to identify threats across health care, including healthcare-associated infections, antibiotic-resistant infections, and antibiotic use (CDC 2026a).

[13] Inpatient psychiatric facilities include freestanding facilities and CMS-certified inpatient psychiatric facility units within a hospital.

[14] There are two options for transmitting bed data: hospitals can send data directly to CDC's NHSN, and states can send data to the NHSN on behalf of hospitals. In either scenario, health IT vendors can send data to the NHSN on behalf of facilities and jurisdictions (CDC 2026a). Facilities may report on occupied and unoccupied adult and pediatric psychiatric beds (CDC 2024). This bed measure provides the census across all CMS-certified pediatric psychiatric beds, which are used to treat serious mental disorders. Care includes monitoring and providing appropriate interventions for behavioral or psychosocial issues (CMS 2024).

[15] During the pilot phase, states recruited facilities to participate, built the automated systems and processes necessary to submit real-time data according to specifications, and began submitting data to the CDC.

[16] To date, 34 states, the District of Columbia, the Commonwealth of the Northern Mariana Islands, and Puerto Rico participate (CDC 2026b).

[17] Through its Epidemiology and Laboratory Capacity funding, the CDC provides funds to states and territories to support health departments' epidemiology, laboratory, and health information systems and to help strengthen their responses to infectious disease threats and public health emergencies (CDC 2026c).

[18] The Health Resources and Services Administration (HRSA) defines a staffed bed as a "licensed and physically available [bed] with staff on hand to attend to patients, including both occupied and available beds" (HRSA 2021).

[19] Interoperability of bed registries and electronic health records is cited as a goal to support implementation and use of bed registries but is difficult to achieve (GAO 2025, BerryDunn 2024, Virginia DBHDS 2020). The status of state efforts to establish bed registries that are interoperable with electronic health records was unavailable.

[20] HealthSource is a non-profit organization serving communities, particularly those with behavioral health needs, throughout the state.

[21] The data include children with Medicaid or CHIP coverage for full or comprehensive benefits who were enrolled for at least six consecutive months.

[22] Other federal data systems collect data on children's mental health, including the National Survey of Children's Health and the National Survey of Drug Use and Health, which asks respondents (i.e., non-institutionalized youth) about past stays in residential settings. HHS also collects case-level information from state and tribal Title IV-E agencies on all children in foster care, including those who live in an institution. Institutions are defined as "a child care facility operated by a public or private agency and providing 24-hour care and/or treatment for children who require separation from their own homes and group living experience" (ACF 2015). These facilities may include: child care institutions, residential treatment facilities, maternity homes, nursing homes, hospitals, etc.

[23] The Consolidated Appropriations Act, 2024 (P.L. 118-42) directed CMS to report annually on several metrics such as the number and distribution of Medicaid beneficiaries and CHIP enrollees using behavioral health services, diagnoses, the types of services used and settings, and delivery systems.

[24] Similarly, there is no federal requirement for the reporting of ED boarding of youth with Medicaid while they await appropriate behavioral health treatment, including residential treatment services. The literature indicates that ED boarding continues to occur for youth with behavioral health issues, including for those with Medicaid coverage (McConnell et al. 2025, Overhage et al. 2024). One analysis of Medicaid claims for youth age 5 to 17 years in 44 states found that 1 in 10 visits resulted in 3 to 7 days of ED boarding in 2022 (McConnell et al. 2025). Rates of ED boarding among youth with Medicaid vary by state and may be affected by the type of mental health conditions the youth experience, state coverage decisions, and bed capacity (McConnell et al. 2025). CMS's calendar year 2026 Hospital Outpatient Prospective Payment System final rule (CMS-1834-FC) established the new Emergency Care Access and Timeliness electronic clinical quality measure as part of CMS's Hospital Outpatient Quality Reporting program. The measure will be calculated using four outcome metrics that quantify access to and timeliness of care in an ED setting, including: (1) patient wait time, (2) whether the patient left the ED without being evaluated, (3) patient boarding time in the ED, and (4) patient ED length of stay. The measure will be stratified by two age groups—younger than 18 years and 18 years and older—and two diagnosis groups—with mental

health diagnosis and without mental health diagnosis. Data collected will also include payer information (eCQI n.d.).

[25] If a state sends a beneficiary out of state, the state must ensure that the receiving PRTF is certified (CMS 2013).

[26] A 2018 survey of Medicare-enrolled hospitals found that 30 percent of rural and 57 percent of urban hospitals had a psychiatrist on staff or available for consultation (Ellison et al. 2022).

[27] The state placed these children in PRTFs or therapeutic group homes. Medicaid covers the cost of care for the majority of the children placed out of state, but care for some children is covered by another state agency such as the state's Department of Corrections or the Child and Family Services Division (Montana DPHHS 2024).

[28] The reporting period is July 1, 2023 to June 30, 2024.

[29] Receiving agencies or placement sites can also contribute to delayed discharge for beneficiaries. The Maryland Hospital Association found that upward of 42 percent of behavioral health patients in EDs faced discharge or transfer delays, most often because beneficiaries are waiting for bed space to become available at their next placement. The same study found that children and youth were likelier to experience a longer delayed discharge compared to an adult (MHA 2019). A Minnesota study of 33 EDs and 13 inpatient units found that approximately 18 percent of behavioral health patients faced delays when being discharged. The most common reasons for delayed discharge from the ED or inpatient settings included a lack of available beds and a waitlist for the receiving facility. Notably, most of the patients who experienced discharge delays in both settings were enrolled in Medicaid or the state's Basic Health Plan, MinnesotaCare (Minnesota DOH 2024).

[30] The Maine Office of Child and Family Services 2018 assessment of children's behavioral health services found that longer lengths of stay in private non-medical institutions could limit the number of children who can be served by them (PCG 2018). Private non-medical institutions provide intensive mental health treatment and rehabilitative services for individuals with mental illness (Office of Behavioral Health 2026). Residential services are intended to be short term (up to six months); however, longer services are often caused by lack of an appropriate service for discharge (PCG 2018).

[31] Section 1945A of the Act provides a state plan option for states to cover health home services, such as care coordination and management, and patient and family support for children with medically complex conditions, including through out-of-state providers. Thus far, states have not implemented this state plan option.

[32] Although the Medicare hospital discharge rules are an example of more detailed discharge requirements, they do not explicitly address unique considerations for discharge from an out-of-state hospital.

[33] West Virginia defines aftercare planning as "[occurring] following placement in an out of home setting…[involving] a clearly delineated process that…always includes the family's involvement…[and] should address every aspect of an individual's life so that when issues arise, they will have the support and guidance to handle the stressors [appropriately and productively]" (WV DHHR 2017).

References

Abdelhalim, A., M. Zargoush, N. Archer, and M. Roham. 2024. Decoding the persistence of delayed hospital discharge: An in-depth scoping review and insights from two decades. *Health Expectations* 27, no. 2: e14050. https://onlinelibrary.wiley.com/doi/full/10.1111/hex.14050.

Administration of Children and Families (ACF). 2015. *A National Look at the Use of Congregate Care in Child Welfare*. Washington, DC: ACF. https://acf.gov/sites/default/files/documents/cb/cbcongregatecare_brief.pdf.

American Academy of Child and Adolescent Psychiatry (AACAP). 2010. *Principles of care for treatment of children and adolescents with mental illnesses in residential treatment centers*. Washington, DC: AACAP. https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/principles_of_care_for_children_in_residential_treatment_centers.pdf.

American Hospital Association (AHA). 2022. *Issue brief: Patients and providers faced with increasing delays in timely discharges*. Washington, DC: AHA. https://www.aha.org/issue-brief/2022-12-05-patients-and-providers-faced-increasing-delays-timely-discharges#.

American Public Human Services Association (APHSA). n.d. ICPC FAQs. Arlington, VA: APHSA. https://aphsa.org/wp-content/uploads/2024/09/ICPC-FAQs.pdf.

Bechir, G., and A. Bechir. 2025. Reducing delays, improving flow: The importance of a dedicated discharge coordinator

in hospital discharge planning. *Cureus* 17, no. 6: e85879. https://pmc.ncbi.nlm.nih.gov/articles/PMC12166983/.

Behavioral Health Administration, Maryland Department of Health. 2026. Behavioral health hospital coordination dashboard. Baltimore, MD: Maryland Department of Health. https://health.maryland.gov/bha/Pages/hospitalcoordination.aspx.

BerryDunn. 2024. *Washington State Health Care Authority (HCA) behavioral health (BH) bed registry and electronic referral tools project*. Olympia, WA: BerryDunn. https://www.hca.wa.gov/assets/program/berry-dunn-needs-assessment-final-report.pdf.

Binder, A., J. Sacht, and J. Patel. 2025. NHSN connectivity initiative: Hospital Bed Capacity Project program updates and overview of key resources. Atlanta, GA: Centers for Disease Control and Prevention. https://www.cdc.gov/nhsn/pdfs/training/2025/2025_Annual_Training_NHSN_Hospital_Bed_Capacity.pdf.

Brown, J., B. Natzke, H. Ireys, et al. 2010. State variation in out-of-home Medicaid mental health services for children and youth: An examination of residential treatment and inpatient hospital services. *Administration and Policy in Mental Health and Mental Health Services Research* 37: 318–326. https://link.springer.com/article/10.1007/s10488-009-0235-x.

Building Bridges Initiative (BBI). 2019. *Comparison of federal requirements for qualified residential treatment programs (QRTP) & psychiatric residential treatment facilities (PRTF).* Sturtevant, WI: BBI. http://www.familyfirstact.org/sites/default/files/BBI QRTP-PRTF Comparison Document - Final.pdf.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2026a. *NHSN Connectivity Initiative: Hospital Bed Capacity Project instruction book.* Atlanta, GA: CDC. https://www.cdc.gov/nhsn/bed-capacity/Connectivity-Initiative_Hospital-Bed-Capacity-Project-Instruction-Book.pdf.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2026b. NHSN Connectivity Initiative: Hospital Bed Capacity Project. Atlanta, GA: CDC. https://www.cdc.gov/nhsn/bed-capacity/index.html.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2026c. The Epidemiology and Laboratory Capacity (ELC) program. Atlanta, GA: CDC. https://www.cdc.gov/epidemiology-laboratory-capacity/php/about/index.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2026. Active provider and supplier counts report: Psychiatric residential treatment facilities, FYs 2000–2026. Baltimore, MD: CMS. https://qcor.cms.gov/Active_PRTFs.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2025. T-MSIS behavioral health (BH) data book: Treatment of BH conditions in Medicaid and the Children's Health Insurance Program, 2023. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/data-and-systems/downloads/macbis/2023-t-msis-bh-data-book.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024. Chapter 2: The certification process. In *State operations manual.* Baltimore, MD: CMS. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107c02.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023. Memorandum from David R. Wright to state survey agency directors regarding "Requirements for hospital discharges to post-acute care providers." June 6, 2023. https://www.cms.gov/files/document/qso-23-16-hospitals.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021. Center for Medicaid and CHIP Services informational bulletin regarding "Guidance on coordinating care provided by out-of-state providers for children with medically complex conditions." October 20, 2021. https://www.medicaid.gov/federal-policy-guidance/downloads/cib102021.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. Center for Medicaid and CHIP Services guidance regarding "Qualified residential treatment programs (QRTP) and serious mental illness (SMI) and serious emotional disturbance (SED) demonstration opportunity: Technical assistance questions and answers." September 20, 2019. https://www.medicaid.gov/federal-policy-guidance/downloads/faq092019.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018. Letter from Mary C. Mayhew to state Medicaid directors regarding "Opportunities to design innovative service delivery systems for adults with a serious mental illness or children with a serious emotional disturbance." November 13, 2018. https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013. Letter from Director Thomas E. Hamilton to state survey agency directors regarding "Provision of inpatient psychiatric services to individuals under the age of 21 (psych under 21 benefit) in out-of-state psychiatric residential treatment facilities (PRTFs)." July 3, 2013. https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/survey-and-cert-letter-13-45.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012. Center for Medicaid and CHIP Services informational bulletin regarding "Inpatient psychiatric services for individuals under age 21." November 28, 2012. https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-11-28-12.pdf.

Civil Rights Division (CRD), U.S. Department of Justice. 2022. *Investigation of the state of Alaska's behavioral health system for children*. Washington, DC: U.S. Department of Justice. https://www.justice.gov/d9/press-releases/attachments/2022/12/15/2022.12.15_alaska_findings_report_0.pdf.

Clemans-Cope, L., and V. Lynch. 2025. Exploring research and practice gaps for suicidality among adults with a disability: Treatment. Washington, DC: Urban Institute. https://www.urban.org/research/publication/exploring-research-andpractice-gaps-suicidality-among-adults-disability.

Connor, D.F., L.A. Doerfler, P.F. Toscano, et al. 2004. Characteristics of children and adolescents admitted to a residential treatment center. *Journal of Child and Family Studies* 13, no. 4: 497–510. https://doi.org/10.1023/B:JCFS.0000044730.66750.57.

Eldeib, D. 2020. Hundreds of children are stuck in psychiatric hospitals each year despite the state's promises to find them homes. *ProPublica*, September 11. https://www.propublica.org/article/hundreds-of-children-are-stuck-in-psychiatric-hospitals-each-year-despite-the-states-promises-to-find-them-homes.

Electronic Clinical Quality Improvement (eCQI) Resource Center. n.d. Emergency Care Access & Timeliness HOQR 1.2.000. Washington, DC: Office of the National Coordinator for Health Information Technology. https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS1244-v1.2.000-QDM.html.

Ellison, A.G, L.A.W. Jansen, F. Nguyen, et al. 2022. Specialty psychiatric services in US emergency departments and general hospitals: Results from a nationwide survey. *Mayo Clinic Proceedings* 97, no. 5: 862–870. https://www.mayoclinicproceedings.org/article/S0025-6196(21)00847-8/.

Etherington, R. 2021. Bed management. Presentation before the Acute Psychiatric Cares Committee, North Dakota Human Services, September 28, 2021, Bismark, ND. https://ndlegis.gov/files/committees/67-2021/23_5054_03000appendixk.pdf.

General Assembly, North Carolina Department of Health and Human Services. 2022. Senate Bill 693: Expedite child safety and permanency. Raleigh, NC: North Carolina Department of Health and Human Services. https://dashboard.ncleg.gov/api/Services/BillSummary/2021/S693-SMBP-76(sl)-v-2.

Golshir, B., and J. Sacht. n.d. Presentation before the National Center for Emerging and Zoonotic Infectious Diseases, Centers for Disease Control and Prevention, Atlanta, GA. https://www.cdc.gov/nhsn/pdfs/training/D1_Connectivity-Initiative_-Hospital-Bed-Capacity-Project_508c.pdf.

Haine-Schlagel, R., and N.E. Walsh. 2015. A review of parent participation engagement in child and family mental health treatment. *Clinical Child and Family Psychology Review* 18: 133–150. https://link.springer.com/article/10.1007/s10567-015-0182-x.

Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services. 2021. Non-Financial Data: What was considered a "staffed bed" for reporting facility metrics? Washington, DC: HRSA. https://www.hrsa.gov/about/faqs/non-financial-data-what-was-considered-staffed-bed-reporting-facility-metrics.

HealthSource Integrated Solutions. 2026. HealthSource Community Bed Board. http://bedcount.healthsrc.org/.

Hill, K. 2017. Prevalence, experiences, and characteristics of children and youth who enter foster care through voluntary placement agreements. *Children and Youth Services Review* 74: 62–70. https://www.sciencedirect.com/science/article/abs/pii/S0190740917301081.

Houghton, A., A. Bowling, K.D. Clarke, et al. 1996. Does a dedicated discharge coordinator improve the quality of hospital discharge? *Quality in Health Care* 5, no. 2: 89–96. https://pmc.ncbi.nlm.nih.gov/articles/PMC1055371/.

Howard, D., Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. 2024. E-mail to MACPAC, June 3.

Ibrahim, H., T. Harhara, S. Athar, et al. 2022. Multi-disciplinary discharge coordination team to overcome discharge barriers and address the risk of delayed discharges. *Risk Management and Healthcare Policy* 15: 141–149. https://pmc.ncbi.nlm.nih.gov/articles/PMC8819168/.

Illinois Department of Children and Family Services (Illinois DCFS). 2023. Annual youth in care waiting for placement report. Report to the General Assembly, Dec. 29. Springfield, IL: Illinois DCFS. https://www.ilga.gov/documents/reports/ReportsSubmitted/4547RSGAEmail9572RSGAAttachP.A.%20100-0087%20DCFS%20FY23%20Youth%20in%20Care%20Waiting%20for%20Placement%20Report.pdf.

Joint Legislative Audit & Review Commission (JLARC). 2022. *CSB behavioral health services.* Richmond, VA: JLARC. https://jlarc.virginia.gov/landing-2022-csb-behavioral-health-services.asp.

Lanier, P., R. Rose, D. Gibbs, et al. 2024. Psychiatric residential treatment facilities for child behavioral health services in North Carolina Medicaid. *North Carolina Medical Journal* 85, no. 3: 54–60. https://ncmedicaljournal.com/article/117075-psychiatric-residential-treatment-facilities-for-child-behavioral-health-services-in-north-carolina-medicaid.

Legislative Audit Council (LAC), South Carolina General Assembly. 2019. *A review of children's behavioral health services*. Columbia, SC: South Carolina General Assembly. https://dc.statelibrary.sc.gov/server/api/core/bitstreams/b08d1e47-b404-4efa-be68-0311a673c687/content.

Mark, T., S. Misra, J. Howard, et al. 2019a. *Inpatient bed tracking: State responses to need for inpatient care.* Washington, DC: Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/reports/inpatient-bed-tracking-state-responses-need-inpatient-care-0.

Mark, T.L., J.N. Howard, S. Misra, and L. Fuller. 2019b. Bed tracking systems: Do they help address challenges in finding available inpatient beds? *Psychiatric Services* 70, no. 10: 921–926. https://psychiatryonline.org/doi/epdf/10.1176/appi.ps.201900079.

Maryland Health Services Cost Review Commission (Maryland HSCRC). 2022. *Behavioral health emergency department wait times and service improvements in Maryland.* Baltimore, MD: Maryland HSCRC. https://dlslibrary.state.md.us/publications/Exec/MDH/HSCRC/HB1121,2020Ch29(2021)_2022.pdf.

Maryland Hospital Association (MHA). 2019. *Executive Summary: Behavioral health patient delays in emergency departments.* Baltimore, MD: MHA. https://mhaonline.org/wp-content/uploads/2024/05/Executive-Summary-Behavioral-Health-Patient-Delays-in-Emergency-Departments.pdf.

Massachusetts Behavioral Health Access (Massachusetts BHA). 2026. Welcome! Boston, MA: Massachusetts Behavioral Health Partnership. https://www.mabhaccess.com/SearchResults.aspx.

McConnell, K.J., T.H.A. Meath, and L.N. Overhage. 2025. Variations in psychiatric emergency department boarding for Medicaid-enrolled youths. *Jama Health Forum* 6, no. 8: e253177. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2837523.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2025a. Chapter 2: Appropriate access to residential behavioral health treatment for children in Medicaid. In *Report to Congress on Medicaid and CHIP*. June 2025. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2025/06/MACPAC_June-2025-Chapter-2.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2025b. Panel on ensuring appropriate access to residential treatment for children and youth in Medicaid., January 2025. https://www.macpac.gov/publication/panel-on-ensuring-appropriate-access-to-residential-treatment-for-children-and-youth/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021. Chapter 3: Access to behavioral health services for children and adolescents covered by Medicaid and CHIP. In *Report to Congress on Medicaid and CHIP*. June 2021. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-3-Access-to-Behavioral-Health-Services-for-Children-and-Adolescents-Covered-by-Medicaid-and-CHIP.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019. *Report to Congress on oversight of institutions for mental disease*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2020/01/Report-to-Congress-on-Oversight-of-Institutions-for-Mental-Diseases-December-2019.pdf.

Micallef, A., S.C. Buttigieg, G. Tomaselli, and L. Garg. 2020. Defining delayed discharges of inpatients and their impact in acute hospital care: A scoping review. *International Journal of Health Policy and Management* 11, no. 2: 103–111. https://pmc.ncbi.nlm.nih.gov/articles/PMC9278600/.

Michigan Department of Health & Human Services (Michigan DHHS). 2025. Electronic inpatient bed registry. Lansing, MI: Michigan DHHS. https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Inside-MDHHS/Budget-and-Finance/MCL-Reports/MCL_330-1151-8_rpt4.pdf.

Minnesota Department of Health (Minnesota DOH). 2024. *Transfer and discharge delays for behavioral health patients at Minnesota hospitals: Results from the 2023 health behavioral health data collection*. St. Paul, MN: Minnesota DOH. https://www.health.state.mn.us/data/economics/docs/dischargedelays.pdf.

Mississippi Department of Mental Health (Mississippi DMH). n.d. State psychiatric hospitals reports. St. Jackson, MS: Mississippi DMH. https://www.ms.gov/dmh-bedregistry/ext/spReports.

Montana Department of Public Health and Human Services (Montana DPHHS). 2024. *MCA 52-2-311: Out-of-state placement annual report, SFY 2024*. Helena, MT: Montana DPHHS. https://archive.legmt.gov/content/Committees/Interim/2023-2024/Children-Families/CFHHS_Meetings/2024_Sept_11/52-2-311-Out-of-State-Placement-Report-FINAL.pdf.

Montana Department of Public Health and Human Services (Montana DPHHS). 2023. Warm hand-off services concurrent with psychiatric residential treatment facility and therapeutic group home: Leveraging warm hand-off services for smoother discharge planning. Helena, MT: Montana DPHHS. https://medicaidprovider.mt.gov/docs/training/2023Training/PRTFTGHWarmHandoffTraining.pdf.

Morrissette, D. 2021. *Improving access to behavioral health crisis services with electronic bed registries.* Alexandria, VA: National Association of State Mental Health Program Directors.

Morrissette, D., and D.A. Pinals. 2018. SAMHSA expert panel on best practices in statewide real-time crisis bed databases. Rockville, MD: Substance Abuse and Mental Health Services Administration. https://www.milbank.org/wp-content/uploads/2019/10/best_practices_in_statewide_real-time_crisis_bed_databases_nasmhpd_presentation_july_2018-4.pdf.

Nebraska Department of Health and Human Services (Nebraska DHHS). 2026a. Lincoln regional center bed capacity and average wait times. Lincoln, NE: Nebraska DHHS. https://app.powerbigov.us/view?r=eyJrIjoiZGZhM-jRiMjUtZjA5MS00OWQxLWIzYTAtZGY0OTFmOTk3NTAxIiwidCI6IjA0MzIwN2RmLWU2ODktNGJmNi05MDIwLTAxMDM4ZjExZjBiMSJ9.

Nebraska Department of Health and Human Services (Nebraska DHHS). 2026b. Norfolk regional center bed capacity and average wait times. Lincoln, NE: Nebraska DHHS. https://app.powerbigov.us/view?r=eyJrIjoiNzk2OWQwOGMtOGJjYS00Nzg1LWI1MDMtMjk2MDczYWVkMzAzIiwidCI6IjA0MzIwN2RmLWU2ODktNGJmNi05MDIwLTAxMDM4ZjExZjBiMSJ9.

North Carolina Department of Health and Human Services (North Carolina DHHS). 2026. Behavioral health statewide central availability navigator. Raleigh, NC: North Carolina DHHS. https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-use-services/crisis-services/behavioral-health-statewide-central-availability-navigator.

NRI. 2018. *Experiences and lessons learned in states with on-line databases (registries) of available mental health crisis, psychiatric inpatient, and community residential placements.* Falls Church, VA: NRI.

NRI. 2017. *Psychiatric bed registries.* Falls Church, VA: NRI. https://nri-inc.org/media/1359/psychiatric-bed-registries-report-2017.pdf.

O'Brien, P.L., M.T. Stewart, M.C. White, et al. 2021. *State residential treatment for behavioral health conditions: Regulation and policy.* Washington, DC: Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/reports/state-residential-treatment-behavioral-health-conditions.

Office of Behavioral Health, Maine Department of Health and Human Services. 2026. Residential treatment: Substance use residential treatment. Augusta, ME: Maine Department of Health and Human Services. https://www.maine.gov/dhhs/obh/support-services/mental-health-services/residential-treatment.

Office of Inspector General (OIG), U.S. Department of Health and Human Services. 2025. *SAMHSA's FindTreatment.gov contained some inaccurate information on substance use and mental health treatment facilities*. Washington, DC: OIG. https://oig.hhs.gov/documents/audit/10243/A-09-23-01003.pdf.

Overhage, L.N., B. Lê Cook, M.B. Rosenthal, et al. 2024. Disparities in psychiatric emergency department boarding of children and adolescents. *JAMA Pediatrics* 178, no. 9: 923–931. https://jamanetwork.com/journals/jamapediatrics/fullarticle/2820959.

Pires, S.A., J. McLean, and K. Allen. 2018. *Faces of Medicaid data series: Examining children's behavioral health service use and expenditures, 2005–2011*. Hamilton, NJ: Center for Health Care Strategies. https://www.chcs.org/media/Childrens-Faces-of-Medicaid-2018_072718-1.pdf.

Public Consulting Group (PCG). 2018. *Children's behavioral health services assessment final report*. Augusta, ME: Maine Department of Health and Human Services. https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/ocfs/cbhs/documents/ME-OCFS-CBHS-Assessment-Final-Report.pdf.

Radel, L., S. Lieff, C. Couzens, et al. 2023. *Behavioral health diagnoses and treatment services for children and youth involved with the child welfare system*. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/sites/default/files/documents/51f80cd88e92eae6c4fc77efada9506b/T-MSIS-Child-Welfare-Overview-Brief.pdf.

Rose, R.A., and P. Lanier. 2017. A longitudinal study of child maltreatment and mental health predictors of admission to psychiatric residential treatment facilities. *International Journal of Environmental Research and Public Health* 14, no. 10: 1141–1156. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5664642/.

Smith, T.E., M. Haselden, T. Corbell, et al. 2022. The effectiveness of discharge planning for psychiatric inpatients with varying levels of preadmission engagement in care. *Psychiatric Services* 73, no. 2: 125–242. https://psychiatryonline.org/doi/epdf/10.1176/appi.ps.202000863.

Smith, T.E., M. Abraham, N.V. Bolotnikova, et al. 2017. Psychiatric inpatient discharge planning practices and attendance at aftercare appointments. *Psychiatric Services* 68, no. 1: 1–32. https://psychiatryonline.org/doi/epdf/10.1176/appi.ps.201500552.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2026. FindTreatment.gov: Frequently asked questions. Rockville, MD: SAMHSA. https://findtreatment.gov/faqs.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2025. FindTreatment.gov: Search for treatment. Rockville, MD: SAMHSA. https://findtreatment.gov/locator.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2024a. Serious mental illness and serious emotional disturbances. Rockville, MD: SAMHSA. https://www.samhsa.gov/mental-health/serious-mental-illness/about.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2024b. National Survey on Drug Use and Health: Table 7.3B—types and locations of mental health treatment and other services in past year: among people aged 12 to 17, by age group, percentages, 2022 and 2023. Rockville, MD: SAMHSA. https://www.samhsa.gov/data/sites/default/files/reports/rpt47100/NSDUHDetailedTabs2023/NSDUHDetailedTabs2023/2023-nsduh-detailed-tables-sect7pe.htm.

Teale, A.L., C. Morgan, T.A. Jenkins, and P. Jacobsen. 2024. Delayed discharge in inpatient psychiatric care: A systematic review. *International Journal of Mental Health Systems* 18: 14. https://pmc.ncbi.nlm.nih.gov/articles/PMC10998409/.

The Joint Commission. 2021. *ED boarding of psychiatric patients—a continuing problem*. Oakbrook Terrace, IL: The Joint Commission. https://digitalassets.jointcommission.org/api/public/content/5663c42eff9a4dbc8c494780bcd9a68f?v=21eb4041.

Tyler, N., C. Planner, M. Byrne, et al. 2021. Developing best practice guidance for discharge planning using the RAND/UCLA appropriateness method. *Frontiers in Psychiatry* 12: 789418. https://pmc.ncbi.nlm.nih.gov/articles/PMC8680088/.

U.S. Government Accountability Office (GAO). 2025. *VA electronic health record modernization: Critical actions needed to support accelerated system deployments.* Report no. GAO-26-108812. Washington, DC: GAO. https://www.gao.gov/assets/gao-26-108812-highlights.pdf.

Virginia Department of Behavioral Health & Developmental Services (Virginia DBHDS). 2021. *Report on HB 728/SB 734: Children's Residential Workgroup report*. Richmond, VA: Virginia DBHDS. https://rga.lis.virginia.gov/Published/2021/RD72/PDF.

Virginia Department of Behavioral Health & Developmental Services (Virginia DBHDS). 2020. Letter from Alison G. Land to Louise Lucas and Mark Sickles regarding "Acute psychiatric bed registry workgroup report." November 6, 2020. https://rga.lis.virginia.gov/Published/2020/RD513/PDF.

West Virginia Department of Health and Human Resources (West Virginia DHHR). July 22, 2017. Safe at Home West Virginia Policy. *Bureau for Children and Families*. Charleston, WV: West Virginia DHHR. https://dhhr.wv.gov/bcf/Services/Documents/SAH%20Policy%20Revised%207-22-17.pdf.

West Virginia Department of Health and Human Resources (West Virginia DHHR). 2013. Chapter 531—covered services, limitations and exclusions for psychiatric residential treatment facility services (PRTF): Change log. Charleston, WV: West Virginia DHHR. https://bms.wv.gov/media/21406/download?inline.

Wulczyn, F., L. Alpert, Z. Martinez, and A. Weiss. 2015. *Within and between state variation in the use of congregate care*. Chicago, IL: The Center for State Child Welfare Data. https://fcda.chapinhall.org/publication/within-and-between-state-variation-in-the-use-of-congregate-care/.

Xiao, S., A. Tourangeau, K. Widger, and W. Berta. 2019. Discharge planning in mental healthcare settings: A review and concept analysis. *International Journal of Mental Health Nursing* 28, no. 4: 816–832. https://onlinelibrary.wiley.com/doi/epdf/10.1111/inm.12599.

Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on May 7, 2026.

Addressing Appropriate Access to Residential Behavioral Health Treatment for Children in Medicaid

4.1 To ensure that states, families, and providers have complete, accurate, and up-to-date information about residential treatment facilities and bed availability, Congress should require that the Secretary of the U.S. Department of Health and Human Services (HHS) develop, maintain, and make publicly available a federally administered, up-to-date, real-time registry of youth residential treatment facilities serving Medicaid beneficiaries. The Secretary should work with HHS agencies, including the Centers for Medicare & Medicaid Services and the Substance Abuse and Mental Health Services Administration, state Medicaid agencies, state behavioral health agencies, and other stakeholders to develop and maintain this registry. The registry should include information on the behavioral health conditions facilities treat, ages served, real-time updates to bed availability for in- and out-of-state Medicaid beneficiaries, and accessibility of facilities and services for individuals with disabilities. The Secretary should leverage information already being collected by federal agencies and states, while also integrating other information needed to determine whether the facility can meet beneficiary need.

4.1 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
No	0	

4.2 To ensure that reliable and consistently collected data are publicly available, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to regularly report on the use of residential treatment services by children and youth in Medicaid, including services provided by psychiatric residential treatment facilities (PRTF), non-PRTFs, and out-of-state residential treatment providers. This report should contain data on the characteristics of youth using the services including demographics, disability and co-occurring conditions, and urbanicity and rurality; types of services used; and average length of stay. The report should include data on the use of emergency departments for behavioral health needs, such as emergency department boarding by youth with Medicaid. If data are unavailable to report on key measures, CMS should develop a plan for collecting

and publicly reporting on the data elements. CMS should engage states, providers, and other stakeholders in developing the data collection and reporting efforts.

4.2 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
No	0	

4.3 To ensure that youth discharged from out-of-state residential treatment facilities return to their home states and communities and receive needed services, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend 42 CFR 441.155 to establish minimum requirements for discharge planning processes that mandate that the process involves all relevant actors including providers, plans, and families and caretakers. The requirements should mandate that the process involves identifying an appropriate community provider or alternative residential placement that has the capability and capacity to accept the beneficiary prior to discharge. CMS should also clarify what entities are responsible for initiating and overseeing the discharge planning process for an out-of-state beneficiary, and establish minimum requirements for coordinating and sharing information between the out-of-state provider and the post-discharge providers.

4.3 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
No	0	

Chapter 5:

Children and Youth with Special Health Care Needs Transitions to Adult Coverage

Children and Youth with Special Health Care Needs Transitions to Adult Coverage

Recommendations

5.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend 42 CFR 435.919(b)(6) to require states to send a notice a minimum of 60 days in advance of children and youth with special health care needs (CYSHCN) aging out of child Medicaid eligibility to inform them that the renewal process has been initiated. CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

5.2 State Medicaid agencies should provide children and youth with special health care needs (CYSHCN) who are aging out of child Medicaid eligibility with a minimum of 30 days to respond to requests for information to complete Medicaid redeterminations in accordance with 42 CFR 435.919(c)(1). CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

5.3 To ensure the accuracy of information provided by the Social Security Administration (SSA) to Medicaid beneficiaries enrolled in Supplemental Security Income (SSI)-related eligibility pathways who are being notified that they are losing eligibility for SSI, the Secretary of the U.S. Department of Health and Human Services, through the Centers for Medicare & Medicaid Services, should coordinate with SSA to review and update model notice language pertaining to Medicaid in SSA's Program Operations Manual System manual paragraphs. The model language should clearly indicate that the individual may retain their Medicaid coverage while the state Medicaid agency takes steps to redetermine the individual on a new basis of eligibility. Additionally, the model language should describe, in general terms, the steps the individual needs to follow to complete the Medicaid redetermination that are specific to 1634, SSI criteria, and 209(b) states.

5.4 State Medicaid agencies should implement optional Medicaid eligibility for children and youth with special health care needs (CYSHCN) up to age 21 who are not otherwise eligible for and enrolled in mandatory coverage or optional full Medicaid coverage under the state plan (42 CFR 435.222 and 42 CFR 435.223). CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

5.5 To ensure children and youth with special health care needs (CYSHCN) receive a full 12-month continuous eligibility period in their final year of child Medicaid eligibility, Congress should amend § 1902(e)(12) of the Social Security Act to require states to provide CYSHCN with a 12-month continuous eligibility period that lasts a full 12 months from the date of the eligibility determination, even if during the continuous eligibility period, an individual reaches the upper age limit for the eligibility pathway by which they are eligible for Medicaid. This 12-month continuous eligibility period should apply to all CYSHCN who receive coverage from a mandatory or optional child eligibility pathway, including optional pathways covering youth above age 18. CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

5.6 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance to states on existing authorities for supporting children and youth with special health care needs (CYSHCN) with Medicaid redeterminations and transitioning to adult Medicaid coverage. The guidance should address authorities to cover case management, transition planning for child-only Section 1915(c) home- and community-based services waivers, and the state optional pathway to cover children up to age 21. CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

Key Points

- Medicaid-covered children and youth with special health care needs (CYSHCN) often navigate multiple, sometimes overlapping, transitions as they reach adulthood. In addition to transitioning from child to adult Medicaid eligibility, they may simultaneously undergo the Supplemental Security Income (SSI) age-18 redetermination and transition from child-only to adult 1915(c) home- and community-based services waivers.
- State Medicaid agencies leverage a number of authorities to ease the Medicaid redetermination process. The majority of CYSHCN (82.4 percent) enrolled in disability-related pathways remained enrolled in Medicaid as adults without experiencing a gap in coverage. However, some CYSHCN experience challenges with this transition. Of the 17.6 percent who disenroll when aging out of child Medicaid, one-third re-enrolled in Medicaid within 12 months.
- Key challenges with the transition to adult Medicaid coverage include insufficient time to prepare and respond to Medicaid redetermination notices; lack of clarity about changes to SSI and how it affects Medicaid eligibility; and inconsistent and sometimes insufficient support with the Medicaid redetermination and other simultaneous transitions.

CHAPTER 5: Children and Youth with Special Health Care Needs Transitions to Adult Coverage

Almost a quarter of all children meet the criteria for having special health care needs, and Medicaid covers more than 40 percent of these children and youth (Black et al. 2024). Children and youth with special health care needs (CYSHCN) are broadly defined by the Maternal and Child Health Bureau (MCHB) as those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition; require health and related services of a type or amount beyond that required by children generally; and have one or more health or functional limitations (MCHB 2025, Black et al. 2024).[1] CYSHCN are often high users of care and may interact with many types of providers (e.g., primary and specialized, care coordinators, case managers) and need prescriptions for their treatment (Schiff et al. 2022). Additionally, Medicaid-covered CYSHCN may be involved with and receive supports from several agencies at the federal, state, and local levels (MACPAC 2025).

When Medicaid-covered CYSHCN approach adulthood, they may need to navigate multiple program age-related transitions (often between age 18 and 26) that occur simultaneously or near simultaneously. These can include transitions from child to adult Medicaid eligibility (most often at age 19); the end of the early and periodic screening, diagnostic, and treatment (EPSDT) requirement (ends at age 21); transitions between Section 1915(c) home- and community-based services (HCBS) waivers (often between age 17 and 22); the age-18 Supplemental Security Income (SSI) redetermination (between age 18 and 19); the end of Title V Maternal and Child Health program services (often by age 21); the end of special education school services (often by age 22); and the end of child welfare support and Medicaid coverage for those who aged out of foster care (age 26) (MACPAC 2025, McManus et al. 2024).[2] Thus, during this transition period, CYSHCN may experience a so-called services cliff due to a reduction or loss of multiple services and supports (Steinway et al. 2017).

The Commission sought to understand Medicaid's role in supporting CYSHCN transitions between child and adult care and Medicaid eligibility and how these transitions may overlap and interact with other program transitions. This work focuses on a narrow scope of Medicaid-covered CYSHCN (about 3.6 percent) who are eligible for Medicaid through either SSI-related eligibility pathways or the Katie Beckett pathway for children with disabilities (enacted under the Tax Equity and Fiscal Responsibility Act of 1982) through state plan or waiver authority, or enrolled in a waiver because they qualify to receive an institutional level of care (MACPAC 2021).[3]

In MACPAC's June 2025 report to Congress, the Commission made recommendations to address barriers in the transition from pediatric to adult care for Medicaid-covered CYSHCN, their families, and their caregivers identified in our research. These recommendations direct: (1) Congress to require states to develop and implement a strategy for CYSHCN transitions from pediatric to adult care that includes developing individualized transition of care plans, (2) the U.S. Department of Health and Human Services (HHS) to direct the Centers for Medicare & Medicaid Services (CMS) to issue guidance on existing authorities for covering transition of care services, (3) HHS to direct CMS to require states to collect and report to CMS on CYSHCN transition-related data, and (4) HHS to direct CMS to require interagency agreements between state Medicaid and Title V agencies to specify the roles and responsibilities of these agencies in supporting CYSHCN transitions from pediatric to adult care (MACPAC 2025).

This chapter describes findings from our examination of CYSHCN transitions between child and adult Medicaid coverage and how this transition overlaps with the Social Security Administration (SSA) age-18 SSI redetermination and the transition between child-only and adult Section 1915(c) HCBS waivers. In this work, the Commission sought to understand the federal requirements for the Medicaid redetermination process and authorities that state Medicaid agencies

can use to ease transitions from child to adult Medicaid coverage for CYSHCN, their families, and their caregivers. We conducted a literature review, federal and state policy scan, stakeholder interviews, and analyses of the Transformed Medicaid Statistical Information System (T-MSIS) and the American Community Survey (ACS).

Research demonstrates that CYSHCN and their families and caregivers experience challenges when transitioning to adult Medicaid that can lead to gaps and loss of coverage (McManus et al. 2024, Okumura et al. 2022, White et al. 2018). For example, recent research indicates that disenrollment among Medicaid-covered individuals peaks at age 19 when they are aging out of child Medicaid (Cliff et al. 2026, McMahon et al. 2025, Smith et al. 2025). Additionally, findings from our analysis of T-MSIS and ACS show that 17.6 percent of Medicaid-covered transition-age youth enrolled in disability pathways disenrolled when aging out. Among young adults with self-reported disabilities, the percentage of Medicaid-covered individuals was lower for those age 19 and 20 to 25 years (39.5 percent and 35.9 percent, respectively) compared to those age 17 to 18 years (48.2 percent) (Appendices 5A and 5B). Disenrollment can be attributed to no longer meeting Medicaid eligibility criteria, transitioning to other sources of coverage, and administrative barriers that prevent beneficiaries from maintaining coverage when they are eligible (Sugar et al. 2021). Gaps and loss of coverage, even for short periods, are associated with delays in receipt of care, an increase in unmet health needs, fewer office-based doctor visits, and an increase in the risk of hospitalization, which can have both short- and long-term health implications (Rennane et al. 2023, Brantley and Ku 2022, Horne et al. 2022, Hemmeter 2011). Additionally, churning (disenrolling and reenrolling in Medicaid within a short period of time) may increase overall Medicaid costs for beneficiaries of all ages due to pent-up demand for care and increased emergency department (ED) utilization after gaps in coverage (Sugar et al. 2021). For example, findings from a 2022 MACPAC study of health care utilization for adults following a gap in Medicaid coverage show that rates of hospitalization and ED use were more than twice as high compared to baseline utilization before disenrollment (MACPAC 2022).

States have many flexibilities and authorities that they can leverage to ease and support the transition to adult Medicaid coverage, including those related to the eligibility redetermination process, optional child and adult eligibility pathways, and the operationalization of their Section 1915(c) HCBS waiver programs. Our findings demonstrate that many states use some of these existing flexibilities and authorities, and our analysis of 2017 through 2019 T-MSIS data indicate that the majority of Medicaid-covered CYSHCN enrolled in disability-related pathways (82.4 percent) remain continuously enrolled during this transition to adult Medicaid coverage (Appendix 5A, Tables 5A-1 and 5A-2). However, our research also identified that despite these state efforts to ease the transition to adult Medicaid, some CYSHCN experience challenges with this transition that can lead to disruptions in their coverage. Challenges include insufficient time to prepare for and respond to Medicaid redetermination notices, lack of clarity in notices from SSA about changes to SSI and SSI-related Medicaid eligibility, navigating eligibility transitions, and variation in the level of support received with Medicaid redeterminations.

The Commission makes six recommendations to address these challenges and improve continuity of coverage as CYSHCN transition to adult Medicaid coverage. The Commission's recommendations are:

5.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend 42 CFR 435.919(b)(6) to require states to send a notice a minimum of 60 days in advance of children and youth with special health care needs (CYSHCN) aging out of child Medicaid eligibility to inform them that the renewal process has been initiated. CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

5.2 State Medicaid agencies should provide children and youth with special health care needs (CYSHCN) who are aging out of child Medicaid eligibility with a minimum of 30 days to respond to requests for information to complete Medicaid redeterminations in accordance with 42 CFR 435.919(c)(1). CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

5.3 To ensure the accuracy of information provided by the Social Security Administration (SSA) to Medicaid beneficiaries enrolled in Supplemental Security Income (SSI)-related eligibility pathways who are being notified that they are losing eligibility for SSI, the Secretary of the U.S. Department of Health and Human Services, through the Centers for Medicare & Medicaid Services, should coordinate with SSA to review and update model notice language pertaining to Medicaid in SSA's Program Operations Manual System manual paragraphs. The model language should clearly indicate that the individual may retain their Medicaid coverage while the state Medicaid agency takes steps to redetermine the individual on a new basis of eligibility. Additionally, the model language should describe, in general terms, the steps the individual needs to follow to complete the Medicaid redetermination that are specific to 1634, SSI criteria, and 209(b) states.

5.4 State Medicaid agencies should implement optional Medicaid eligibility for children and youth with special health care needs (CYSHCN) up to age 21 who are not otherwise eligible for and enrolled in mandatory coverage or optional full Medicaid coverage under the state plan (42 CFR 435.222 and 42 CFR 435.223). CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

5.5 To ensure children and youth with special health care needs (CYSHCN) receive a full 12-month continuous eligibility period in their final year of child Medicaid eligibility, Congress should amend § 1902(e)(12) of the Social Security Act to require states to provide CYSHCN with a 12-month continuous eligibility period that lasts a full 12 months from the date of the eligibility determination, even if during the continuous eligibility period, an individual reaches the upper age limit for the eligibility pathway by which they are eligible for Medicaid. This 12-month continuous eligibility period should apply to all CYSHCN who receive coverage from a mandatory or optional child eligibility pathway, including optional pathways covering youth above age 18. CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

5.6 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance to states on existing authorities for supporting children and youth with special health care needs (CYSHCN) with Medicaid redeterminations and transitioning to adult Medicaid coverage. The guidance should address authorities to cover case management, transition planning for child-only Section 1915(c) home- and community-based services waivers, and the state optional pathway to cover children up to age 21. CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI

as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

This chapter begins with background on the Medicaid-covered CYSHCN population, including their eligibility pathways and benefits. It then describes the transition from child to adult Medicaid coverage, including the federal requirements for Medicaid redeterminations and transitions between Section 1915(c) HCBS waivers, and key findings on adult Medicaid coverage transition outcomes. Then it presents findings on the state role in facilitating the transition to adult Medicaid coverage and approaches to easing this process. Next it describes the four key challenges beneficiaries experience with the transition to adult Medicaid coverage. Finally, the chapter presents the Commission's six recommendations and associated rationale as well as implications for federal spending, states, enrollees, plans, and providers.

Medicaid-Covered CYSHCN

More than 40 percent of CYSHCN are covered by Medicaid or a combination of Medicaid and private insurance (37.2 percent and 7.6 percent, respectively) (MACPAC 2024). Medicaid-covered CYSHCN can enroll on the basis of income or disability, which includes mandatory SSI-related pathways and state optional disability pathways. Optional disability-related pathways include the state medically needy pathway option, state plan options established by the Family Opportunity Act of 2005 (P.L. 109-171), the Section 1915(i) state plan HCBS benefit pathway, and the optional Katie Beckett pathway for children with disabilities or Katie Beckett waiver (Musumeci and Chidambaram 2019).[4]

Most Medicaid beneficiaries enrolled in mandatory SSI-related eligibility pathways are also eligible for SSI, but the Medicaid enrollment processes vary between states.[5] Based on legislative flexibilities that Congress has afforded to states, states can use three approaches when determining Medicaid eligibility for SSI-enrolled individuals:

- **1634 states (35 states and the District of Columbia):** Section 1634 of the Social Security Act (the Act) allows SSA to enter into an agreement with state Medicaid agencies in which SSA determines Medicaid eligibility for individuals who are eligible for SSI. In these states, referred to as "1634 states," a determination of eligibility for SSI confers Medicaid eligibility, and the beneficiary remains Medicaid eligible as long as they remain SSI eligible (42 CFR 435.541). SSI-eligible individuals are not required to submit a separate Medicaid application.
- **SSI criteria states (8 states):** Medicaid programs in these states use SSI methodology when determining Medicaid eligibility on the basis of disability. These states do not have a Section 1634 agreement with SSA, so if an individual applies to SSA for SSI, they must also submit a separate Medicaid application to the state Medicaid agency to enroll in Medicaid because SSI eligibility does not automatically confer categorical eligibility for Medicaid (42 CFR 435.541).
- **209(b) states (8 states):** Section 209(b) of the Act, Amendments of 1972, allows states to use Medicaid eligibility criteria (related to income and assets, disability, or both) that are more restrictive than SSI program criteria. Individuals who are eligible for SSI must separately apply to Medicaid to be determined eligible for Medicaid coverage.

States may choose to cover optional benefits under the state plan or through waiver programs. For example, states can use waiver authority to cover services not covered under the state plan, including HCBS. Furthermore, Section 1915(c) HCBS waiver authority allows states to cover a broad array of HCBS to eligible individuals, which can include CYSHCN, or a subset of them, who meet an institutional level of care. At the time of our review in 2025, 34 states operated a total of 51 age-limited child-only 1915(c) HCBS waiver programs with state-determined age-related eligibility limits (e.g., age 0–5 or up to age 21) and condition-specific eligibility criteria (e.g., specific diagnoses). Additionally, all Medicaid-covered children up to age 21 who are enrolled in Medicaid through the categorically needy pathway are entitled to benefits under the EPSDT requirement (42 CFR 441.56).

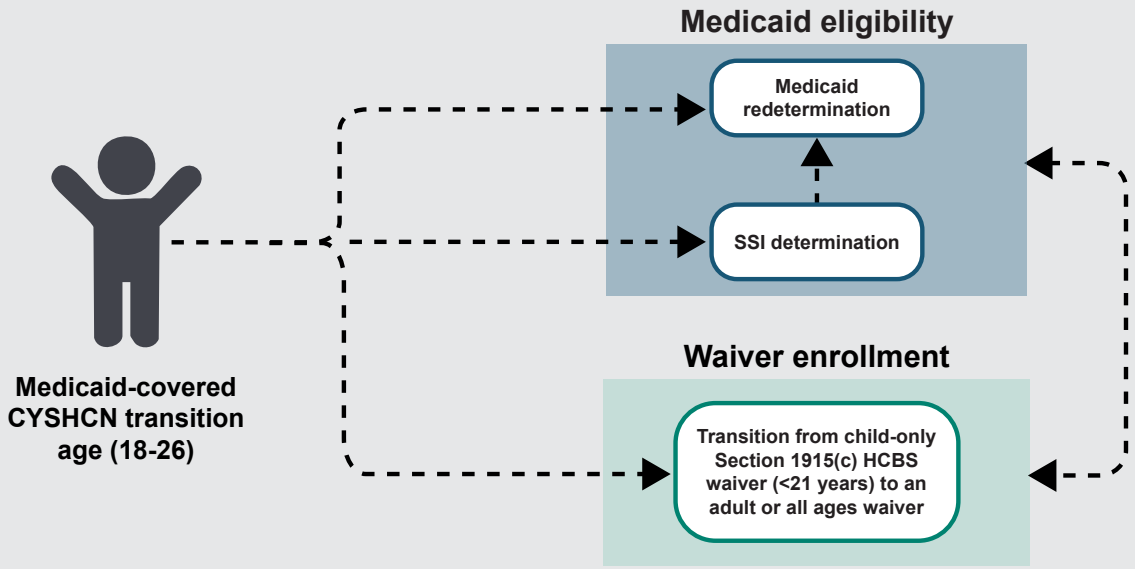
Section 1905(a)(4)(B) and (r) of the Act requires states to provide EPSDT-eligible children coverage for all medically necessary services that could be covered under the mandatory and optional services in section 1905(a), regardless of whether such services are covered under the state plan. The EPSDT requirement extends beyond the upper age limit for most children's eligibility pathways, so youth who receive these benefits up to age 21 are often receiving Medicaid coverage as adults.

States may also choose to expand financial eligibility for waiver services through optional pathways, such as the medically needy pathway or the special income-level pathway (MACPAC 2023). Additionally, Public Law 119-21, an Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 amended Section 1915(c) of the Act to create a new HCBS waiver option for states to establish a standalone 1915(c) HCBS waiver that does not require beneficiaries to meet an institutional level of care.[6]

Transitions from Child to Adult Medicaid Coverage

When Medicaid-covered CYSHCN age into adulthood, they often navigate multiple transitions between age 18 and 26, including the transition from child to adult Medicaid coverage (Figure 5-1). During this transition period, CYSHCN can be enrolled in and receive services and supports from several programs, including Section 1915(c) HCBS waivers, SSI, state Title V programs, special education services, and child welfare. The timing of the child-to-adult transitions associated with these programs may

FIGURE 5-1. Children and Youth with Special Health Care Needs Medicaid Eligibility and Waiver Enrollment



Notes: SSI is Supplemental Security Income. CYSHCN is children and youth with special health care needs. HCBS is home- and community-based services.

Source: MACPAC analysis, 2025.

overlap and interact with the Medicaid redetermination at age 19 in most states (MACPAC 2025, McManus et al. 2024). For example, for youth enrolled in SSI-related Medicaid pathways reaching adulthood, the Medicaid redetermination may overlap with the SSI age-18 redetermination (Box 5-1). The outcome of the SSI redetermination affects the beneficiary's Medicaid eligibility pathway. Additionally, beneficiaries enrolled in an age-limited child Section 1915(c) HCBS waiver may need to transition to an adult or all ages waiver to maintain access to HCBS services. In some cases, waiver enrollment can confer Medicaid eligibility for individuals who would not otherwise be eligible for Medicaid through a mandatory pathway. Thus, the outcome of the 1915(c) HCBS waiver transition can affect the beneficiary's Medicaid eligibility as well.

Transition to adult Medicaid outcomes

Research demonstrates that disenrollment from Medicaid is greatest for youth when they reach age 19, when they are transitioning out of child Medicaid eligibility and may be experiencing multiple simultaneous or near simultaneous transitions (Cliff et al. 2026, MACPAC 2025, McMahon et al. 2025, Smith et al. 2025). Findings from our analysis of the 2023 ACS demonstrate that there are differences in insurance coverage between youth (age 17–18) and young adults (age 19–25) with self-reported disabilities (Appendix 5B, Table 5B-1). For example, the percentage of individuals who were Medicaid covered was greater for those age 17 to 18 (48.2 percent) compared to those age 19 (39.5 percent) and 20 to 25 (35.9 percent). Across these same groups, a higher percentage of young adults (age 19 and 20–25) reported having private coverage (50.1 percent and 49.5 percent, respectively) or being uninsured (8.7 percent and 12.0 percent, respectively) compared to those age 17 to 18 (44.3 percent and 5.8 percent, respectively).

Findings from our analysis of 2017 through 2019 T-MSIS eligibility and enrollment data indicate that 17.6 percent of Medicaid-covered youth enrolled in disability-related pathways disenrolled when aging out of child Medicaid and experienced a disruption in Medicaid coverage (Appendix 5A, Table 5A-2). Of those who disenrolled, about 34 percent churned back onto Medicaid within 12 months, and the remaining 66 percent did not reenroll within 12 months.

BOX 5-1. Supplemental Security Income Age-18 Redeterminations

Individuals eligible for Supplemental Security Income (SSI) as a child must have their SSI eligibility redetermined at age 18 to continue to receive SSI benefits as an adult (SSA 2024a). The Social Security Administration (SSA) is required to initiate the age-18 redetermination for SSI within a year after an individual turns 18 years old (20 CFR 416.987). Starting at age 14, SSA sends an annual notice email to individuals about the age-18 redetermination so the enrollee and their family can prepare for the transition. The annual notice includes a link to educational resources that describe the age-18 redetermination and how to appeal if they are determined ineligible as an adult (SSA 2024a, n.d.b).

The SSI disability criteria differ for children (up to age 18) and adults (18 and older). Child disability is determined based on functional limitations, abilities of children compared to those of children without impairments, and deemed parent income (SSA 2001). The adult disability determination is defined by functional impairments, which are assessed based on the ability to work and perform substantial gainful activity, and only the individual's income is counted (SSA 2023). Due to the differences in child and adult disability and financial criteria for SSI, not all individuals eligible for SSI as children are determined eligible as an adult. In 2023, more than 66,000 children eligible for SSI were redetermined as an adult at age 18. Of these children, 48 percent were determined eligible for SSI as adults, and 52 percent were not. Of those who were not determined eligible, 42 percent appealed the decision (SSA 2024b).

Our analysis also identified the eligibility pathways that the young adults enroll in as adults. For example, the majority of transition-age youth enrolled in disability-related pathways (e.g., SSI-related pathways) who remained continuously enrolled then enrolled in the same pathway as an adult (77.9 percent) (Appendix 5A, Figure 5A-1). In contrast, of those who churned, only 14.1 percent reenrolled in the same pathway, and 50.3 percent reenrolled in a modified adjusted gross income (MAGI) pathway (including the adult expansion pathway) (Appendix 5A, Figure 5A-2). Additional findings from this analysis are published in the 2026 MACPAC issue brief *CYSHCN Transitions to Adult Medicaid Coverage* (MACPAC 2026).

Our T-MSIS analysis also identified state variation in the percentage of youth enrolled in disability-related pathways who remained continuously enrolled as they transitioned to adult Medicaid coverage (ranging from 64.5 to 95.6 percent) (MACPAC 2026). For example, we identified differences in the share who remained continuously enrolled, churned, and disenrolled between those enrolled in states that had adopted Medicaid expansion and those enrolled in states that did not (Appendix 5A, Figure 5A-3). A larger percentage of beneficiaries in expansion states who were enrolled in SSI-related pathways and other disability-related pathways as a child remained continuously enrolled as an adult compared to those in non-expansion states (88.3 percent compared to 78.7 percent and 74.6 percent compared to 59.7 percent, respectively). In addition to Medicaid expansion, many other state Medicaid policies could contribute to state variation, such as state Medicaid redetermination procedural differences (e.g., number of days for beneficiaries to respond to requests for information) and state adoption of optional pathways and child-only 1915(c) HCBS waivers that allow individuals to be enrolled beyond age 18 (Cliff et al. 2026, Musumeci et al. 2025, Alker et al. 2024).

Federal Medicaid redetermination requirements

Federal Medicaid redeterminations for children must occur every 12 months; more frequent redeterminations are not permitted. Federal law requires states to provide 12 months of continuous eligibility for all children younger than age 19 (§ 1902(e)(12)(A) of the Act). For Medicaid redeterminations, state Medicaid agencies must first attempt to confirm ongoing eligibility using reliable information available to the agency without requiring information from the individual, known as "ex parte" or "administrative renewal" (42 CFR 435.916(b)(1)). Furthermore, as a part of the 2024 Streamlining Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes final rule (E&E), CMS added section 42 CFR 435.919 to define state redetermination responsibilities related to changes in circumstance, including anticipated changes (e.g., aging out of a child eligibility pathway). These requirements are yet to be implemented due to the moratorium put in place by the 2025 Budget Reconciliation Act, but states have the option to implement these provisions (Box 5-2). In accordance with 42 CFR 435.919(6), states should initiate and complete the redetermination process in advance of the child turning 19 years old. Federal rules do not specify how much lead time is required or require states to inform beneficiaries that the redetermination process has been initiated, but many states initiate redeterminations between 60 and 90 days before the end of the eligibility period (CMS 2024a).

States are required to send beneficiaries notices about the agency's decision or a request for information if additional information is needed from the beneficiary to complete the redetermination. For example, if the state identifies information that will lead to termination, reduced benefits (e.g., change in eligibility pathway), or increases in premiums or cost sharing, the state is required to contact the beneficiary and offer them an opportunity to provide new information before making changes to their eligibility (42 CFR 435.917, 42 CFR 435.952(d)). States that request information from beneficiaries are required to complete timely redetermination (42 CFR 435.912), including providing MAGI beneficiaries with a minimum of 30 days to respond to requests for information (42 CFR 435.916(b)(2) and 435.919(c)). The 2024 E&E final rule expanded this requirement to include non-MAGI beneficiaries. The implementation of this provision of the final rule was paused by the 2025 Budget Reconciliation Act, but states still have the option to implement it (Box 5-2). If an individual does not respond to the request for information within the required time frame, before termination, the state must assess all possible eligibility pathways (42 CFR 435.916(d)(1) and 42 CFR 435.911).

BOX 5-2. Moratorium on Certain Provisions in the 2024 Eligibility and Enrollment Final Rule

The 2024 Centers for Medicare & Medicaid Services (CMS) *Streamlining Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes* (E&E) final rule implemented changes to help with Medicaid enrollment and promote retention and redetermination of eligible individuals. The finalized provisions include aligning application and renewal requirements for Medicaid beneficiaries enrolled in a non-modified adjusted gross income (MAGI) pathway with those applicable to the MAGI population (CMS 2024b).

The Public Law 119-21, an Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14 put a moratorium on the implementation of provisions in the 2024 E&E final rule that were not in effect as of July 4, 2025, until fiscal year 2035. The 2025 Budget Reconciliation Act prevents CMS from enforcing these new federal requirements, although states can still adopt many of these changes by exercising their own authority to design their program (Erzouki 2025). For example, the E&E final rule amended 42 CFR 435.916(b)(2) and added 435.919(c) to require state Medicaid agencies to provide non-MAGI beneficiaries with a minimum of 30 days to respond to requests for information. This new requirement aligns non-MAGI and MAGI requirements, and states were expected to implement this change by June 3, 2027 (CMS 2024b). Although CMS cannot enforce the required implementation of this provision, states still have the authority to implement this change. Throughout the chapter, we discuss some Medicaid redetermination requirements that are subject to the 2025 Budget Reconciliation Act.

Additionally, if the individual is eligible for multiple categories, they must have a choice in the pathway selection (42 CFR 435.404).

Medicaid redetermination for beneficiaries eligible on the basis of disability. For CYSHCN enrolled in SSI-related pathways as a child, the Medicaid redetermination process varies based on whether they are enrolled in a 1634, SSI criteria, or 209(b) state and whether they remain SSI enrolled as an adult. In 1634 and SSI criteria states, state Medicaid agencies use SSI criteria for disability determinations. If SSA has made a disability determination for an individual in these types of states, the state generally must use SSA's disability determination, rather than conducting a separate disability determination, when redetermining Medicaid eligibility (42 CFR 435.541). For example, in 1634 states, if a beneficiary was enrolled in SSI as a child and remains enrolled in SSI as an adult, the individual continues to be automatically eligible for Medicaid, and the state does not need to take any action to complete an ex parte redetermination. In SSI criteria states, the state can complete the ex parte process by confirming SSI eligibility with SSA. In contrast, in 209(b) states, in which SSI eligibility does not confer Medicaid eligibility, the state cannot complete a Medicaid redetermination only on the basis of SSI disability (CMS 2024a).

Medicaid redetermination for beneficiaries not eligible on the basis of disability. The Medicaid redetermination process is different for those who had SSI as a child and lose SSI as an adult and beneficiaries who were not enrolled in an SSI as a child. If a beneficiary is not redetermined eligible for SSI as an adult, SSA will notify the state Medicaid agency, prompting it to conduct a change in circumstance redetermination (42 CFR 435.919). In 1634 states, Medicaid beneficiaries do not apply separately to Medicaid, so when an individual loses SSI, the state must first attempt to redetermine them on an ex parte basis, but they may not have sufficient information to complete the redetermination. In these cases, beneficiaries must provide the state with additional information to complete the redetermination on a new basis. In SSI criteria and 209(b) states,

beneficiaries submit a separate Medicaid application, so in some cases the state may be able to complete redeterminations on an ex parte basis.

When a Medicaid beneficiary loses SSI, SSA will send the individual a notice informing them of this loss. SSA is required to send notices to individuals about changes to their SSI eligibility, which must include information about SSI determinations and decisions and rights to appeal and explain the reason for the decision (SSA 2025a). In states where SSI eligibility confers Medicaid eligibility, the notice includes information on their SSI-related Medicaid coverage (20 CFR 416.987 and 20 CFR 416.1336). The SSA notice specifies that these individuals no longer qualify for Medicaid based on SSI rules and that there may be other pathways for Medicaid eligibility. Additionally, the notice may include state-specific Medicaid eligibility information (e.g., state Medicaid agency contact information) and instruct individuals to contact the state Medicaid agency to determine if they are still eligible for Medicaid (SSA 2025b, 2011).

Transition planning requirements for age-limited 1915(c) HCBS waivers

States operating age-limited 1915(c) HCBS waivers must provide transition planning for beneficiaries enrolled in these waivers to support beneficiaries with maintaining continuity of services to the extent feasible. The Section 1915(c) HCBS technical guide indicates that transition planning may include certain activities (e.g., identifying and informing individuals about waivers they may qualify for), but it does not specify or prescribe specific parameters for planning procedures related to Medicaid redeterminations and continuity of coverage (CMS 2024c). Findings from our review of all child-only 1915(c) HCBS waivers indicate that most of these waivers specify who is responsible (e.g., case manager, care coordinator, or service coordinator) for notifying and supporting the beneficiary and family with the transition to an adult or all ages 1915(c) HCBS waiver. Additionally, a few waivers specify that beneficiaries who are not eligible for adult waiver services can receive transition support.

State Role in Supporting CYSHCN Transitions to Adult Medicaid

State Medicaid agencies can leverage a number of authorities to ease the Medicaid redetermination process and transitions between child-only and adult 1915(c) HCBS waivers and support continuity of coverage.

Medicaid eligibility and redetermination flexibilities

Findings from our state scan and stakeholder interviews demonstrate that many states leverage existing flexibilities and authorities to ease Medicaid eligibility and redeterminations processes for beneficiaries transitioning to adult Medicaid. State approaches include using the SSI disability determination for Medicaid eligibility determinations, sending advance notice of upcoming Medicaid redeterminations, adopting state optional pathways, and using various authorities to provide CYSHCN with support during the transition.

Type of disability determination state (e.g., 1634, SSI criteria, and 209(b)). One of the factors affecting whether states can complete ex parte disability-related redeterminations is the state's use of SSI eligibility criteria when making Medicaid determinations. For example, 1634 and SSI criteria states use the SSA disability determination as the basis for Medicaid eligibility (42 CFR 435.541). Additionally, state officials in 1634 and SSI criteria states shared that beneficiaries who are SSI eligible as children and remain enrolled as adults will remain eligible and enrolled in the same SSI-related Medicaid eligibility pathway. However, in 1634 states, the Medicaid agency may ask beneficiaries who had SSI as a child and are no longer eligible as an adult to provide additional information to complete a Medicaid redetermination on a different basis. For example, one 1634 state shared that they may be able to use data from SSA to complete an ex parte redetermination, but often more information is needed from the beneficiary.

In these states, SSI enrollees do not submit a separate Medicaid application, so when they lose SSI, the state Medicaid agency may be missing information to assess eligibility. In contrast, SSI criteria states, where beneficiaries submit a separate Medicaid application, have more information about the beneficiary, such as household income, so the state may be able to complete the redetermination without requesting additional information from the beneficiary.

Advance notice of upcoming Medicaid redetermination. States are not required to send beneficiaries notices in advance of their Medicaid redetermination unless additional information is needed, but recent state survey findings indicate that 20 states contact beneficiaries in advance of initiating the renewal (Brooks 2025). Interviewed states and national and state-level advocates shared that sending beneficiaries and families advance notice of the upcoming age-19 Medicaid redetermination helps them prepare for this process and ensure they have the information needed to maintain Medicaid coverage. Similarly, one interviewed state official shared that their state sends beneficiaries letters and emails as early as a year in advance of the beneficiary aging out of their child eligibility pathway to improve their awareness of the upcoming redetermination.

State optional pathways. States have the flexibility to adopt optional eligibility pathways to cover beneficiaries who may not otherwise be eligible for any mandatory pathways. Findings from our work indicate that many beneficiaries aging out of child Medicaid coverage and losing SSI eligibility enroll in the optional adult expansion pathway in states that have adopted it (Appendix 5A, Figures 5A-3 and 5A-4) (MACPAC 2026). For example, findings from our T-MSIS analysis show that about 20 percent of individuals enrolled in SSI-related pathways as children who transitioned to adult coverage (continuously or churned) did not remain enrolled in analogous pathways as adults, and about half of these beneficiaries enrolled in an adult MAGI pathway. Of those who enrolled in a MAGI pathway, about half enrolled in the expansion pathway if they lived in a state that had adopted this option. Additionally, several interviewees indicated that CYSHCN who were enrolled in disability-related Medicaid pathways and who lose SSI as an adult also retain Medicaid coverage through the adult expansion pathway. The income eligibility threshold for the expansion group is greater than that of SSI, and it does not have asset limits, which allows many adults with disabilities with incomes above the SSA limit to qualify for Medicaid (Machledt 2024).[7] Furthermore, two states shared that beneficiaries awaiting an adult SSI determination or who are on a Medicaid waiver waitlist may be able to maintain Medicaid coverage under the adult expansion pathway.

Four states have implemented an optional child eligibility pathway that allows states to extend childhood eligibility up to age 21 (42 CFR 435.222 and 42 CFR 435.223).[8] For this eligibility pathway, individuals must also have a household income at or below the standard established by the state for the particular age group or reasonable classification of individuals and not be eligible for mandatory coverage under the state plan.[9] Additionally, in expansion states, individuals cannot enroll in this pathway if they are eligible for the expansion pathway, and the child eligibility pathway household income criteria must be above the maximum income eligibility for the expansion pathway (133 percent of the federal poverty level (FPL)) (CMS n.d.). The states that have implemented this optional child eligibility pathway provide coverage to targeted populations. For example, the District of Columbia, Florida, and Massachusetts extended eligibility for children age 19 and 20 who are not eligible for or enrolled in another mandatory pathway with state-specific income criteria (CMS 2014, 2013a, 2013b). In 2023, Maine extended eligibility for children age 19 and 20 and increased the upper income limit for all children younger than 21 to 300 percent FPL. Maine's state plan amendment specified that individuals are eligible for this pathway only when they are not eligible or enrolled in any other mandatory or state optional pathway (CMS 2023a).

Findings from our work indicate that extending child eligibility up to age 21 can increase coverage stability during the transition to adulthood and reduce the risk of delayed or missed care due to churn. Interviewed states that have extended child eligibility to older than age 18 shared that delaying the coverage transition to adult Medicaid gives beneficiaries and families more time to navigate the many other program transitions

that occur during this period. Some of these transitions include those that may affect a beneficiary's ability to remain Medicaid-covered (e.g., applying to SSI as an adult, enrolling in an adult 1915(c) HCBS waiver). Additionally, interviewed advocates and some states noted that extending eligibility up to age 21 would align with the EPSDT age limit and other services received outside of Medicaid. For example, some CYSHCN receive services and supports from state Title V programs, such as coordination and case management services as well as educational resources, typically up to age 21 (McManus et al. 2024).

Support with Medicaid redeterminations. State Medicaid agencies and other entities can help beneficiaries with the Medicaid redetermination process and ease the transition to adult Medicaid coverage. State Medicaid agencies, managed care organizations, waiver case managers, other state agencies, and community-based organizations such as family-to-family networks often provide such support.[10] For example, advocates shared that family-to-family networks can provide beneficiaries and families with educational resources and assist them with the paperwork for both SSI and Medicaid redeterminations. Additionally, state 1915(c) HCBS waiver programs often cover case management services, which can include supporting beneficiaries with transitions. The role of the case manager can vary by waiver, but often they are responsible for supporting beneficiaries' transitions between benefit programs (e.g., Medicaid and SSI) and helping them understand waiver program rules and requirements (Saraswathula and Colello 2025). Furthermore, states can provide case management and targeted case management (TCM) through their state plan to specific populations, including CYSHCN, to support their transitions of coverage and care (42 CFR 440.169). However, MACPAC's earlier work on transitions from pediatric to adult care found that states do not currently use TCM to provide transition of coverage or care-related services for CYSHCN (MACPAC 2025).

Our findings indicate that having a dedicated case manager or care coordinator is particularly important because of the role they can play in helping beneficiaries and families navigate waiver enrollment processes, SSI redeterminations, and Medicaid coverage transitions. Many interviewees shared that children enrolled in waivers, in comparison to those who are not, are often able to maintain coverage as adults because of the case management services they receive through the waiver. Waiver case managers can serve beneficiaries in many ways, including helping families understand the Medicaid and SSI redetermination processes, request required medical forms, and fill out and submit required documentation. However, advocates and state Medicaid officials noted that ongoing workforce issues can affect the amount of support beneficiaries receive during this transition, even when they are enrolled in a waiver program. Advocates noted that beneficiaries who are not enrolled in an HCBS waiver may not receive any dedicated support from the state.

Section 1915(c) HCBS waiver program flexibilities

States have flexibility in how they design and operationalize their 1915(c) HCBS waiver programs. Findings from our state policy review and stakeholder interviews indicate that many states have taken many different approaches to leveraging these flexibilities (e.g., transition planning procedures, reserve capacity, waitlists) to ease the transition between child-only and adult 1915(c) HCBS waivers.

Section 1915(c) HCBS waiver program design. Some states with multiple 1915(c) HCBS waivers have designed corresponding child and adult waiver programs to promote continuity of care for beneficiaries transitioning from the child to adult waiver. For example, one state designed its corresponding child-only and adult 1915(c) HCBS waivers to have overlapping age eligibility and allows beneficiaries enrolled in the child-only waiver (enrollment up to age 21) to choose to enroll in the adult waiver beginning as early as age 18 (minimum allowable age). This approach allows beneficiaries to have flexibility in choosing when to transition between waivers and gives them multiple years to complete the transition. Another state allows beneficiaries enrolled in a child-only waiver to remain enrolled until they enroll in a new waiver or are determined ineligible for all other state Medicaid waiver programs, even if enrollment extends past the child-only waiver upper age limit. Furthermore, some states shared that they allow individuals to remain enrolled in child-only 1915(c) HCBS waivers as adults as long as they were

enrolled as a child and did not disenroll before the age-out upper limit.

Transition planning. States with age-limited Section 1915(c) HCBS waivers must specify waiver transition planning procedures for individuals aging out of the waiver to support beneficiaries with maintaining continuity of services. States have flexibility in defining the transition planning activities, which can include identifying and informing individuals about public programs and waivers that they may qualify for and providing them with priority consideration for other state Medicaid waivers (CMS 2024c). Some state officials shared that they designate case managers to help beneficiaries with identifying and applying for waivers and with completing the functional and level of care assessments.[11] Additionally, state officials shared that case managers can inform the beneficiary and their family about upcoming Medicaid and SSI redeterminations and provide resources and referrals to community-based organizations that may be able to provide additional support. Furthermore, some states specify in their transition planning procedures that the designated case manager will help the beneficiary and family apply for other benefits programs if they are no longer eligible for Medicaid or a waiver as an adult.

Reserve capacity. With approval from CMS, states can designate a predetermined number of reserve capacity spots in their Section 1915(c) HCBS waiver for individuals who are transitioning from another waiver, including those aging out of a child-only waiver (CMS 2024c). For example, two interviewed states shared that they reserve capacity in their adult 1915(c) HCBS waivers for beneficiaries age 18 to 21 years who are transitioning from a child-only intellectual and developmental disability or autism waiver. States are permitted to have waitlists for their waivers, which can delay the transition to adult waivers; however, reserve capacity can be used to allow some beneficiaries to bypass the waitlist. For example, one interviewed state shared that they automatically enroll beneficiaries aging out of their child developmental disability waiver into the adult developmental disability waiver, even though the adult waiver has a waitlist. Several advocates and states with reserve capacity shared that, in general, reserving capacity in their adult waivers works well and helps beneficiaries maintain needed waiver enrollment and services.

Challenges with CYSHCN Transitions to Adult Medicaid

Our findings show that state Medicaid programs have taken steps to improve transitions to adult Medicaid and support CYSHCN and their families with navigating Medicaid redeterminations and other related program transitions. Additionally, findings indicate that the majority of children transition to adult Medicaid coverage without experiencing a gap in coverage. Of those who disenroll, almost half churn back onto Medicaid through the state optional expansion pathway. However, our research also found that some CYSHCN and their families experience challenges with this transition that can lead to a loss or gap in coverage.

Insufficient time to prepare and respond to Medicaid redetermination notices

Beneficiaries and families may not receive a notification or reminder of the upcoming redetermination in advance of the age-19 Medicaid redetermination or have sufficient time to provide documentation to complete this redetermination process. Advocates shared that sometimes beneficiaries receive their redetermination request for information notice too late to respond within the required time frame, after the deadline, or do not receive the notice at all. For example, in our state interviews, we heard that there can be delays in receiving mail in rural areas, contributing to beneficiaries receiving notices after the response deadlines. If a beneficiary does not complete the steps detailed in the notice in a timely way, their coverage may be terminated. In 1634 states where Medicaid eligibility is automatic for SSI-eligible individuals, the beneficiary and family have never applied to Medicaid, so they may not be aware of the Medicaid redetermination process or the requirement that they have to send information to the Medicaid agency to maintain Medicaid coverage. Additionally, advocates described that the redetermination request for information notices sent to beneficiaries often lack clear and actionable steps in plain language, leading

to beneficiary and family confusion about how to respond to maintain coverage. The notices terminating coverage may similarly lack clear language about their change in eligibility and benefits.

Lack of clarity in notices from SSA about changes to SSI and Medicaid eligibility

Beneficiaries and families experience challenges with understanding how a loss of SSI affects their Medicaid eligibility. Advocates described SSA notices as sometimes lacking clear and actionable steps to retain Medicaid coverage in 1634 states. In our research, interviewees shared that the notification from SSA sometimes incorrectly states that a loss of SSI eligibility results in a termination of Medicaid. When an individual has a change in circumstance (e.g., loss of SSI, change in income), the state Medicaid agency is required to redetermine their eligibility based on other pathways before terminating coverage (42 CFR 435.916(d)(1)). Furthermore, in accordance with Section 1902(e)(12) of the Act, the state is not permitted to terminate coverage of those who are younger than age 19 until the individual reaches the end of their 12-month enrollment period, except in cases when the individual attains age 19 or moves out of state. Interviewees indicated a need for improving the language in SSA notices about losing SSI eligibility to ensure the information about the effect on Medicaid eligibility is accurate. Furthermore, the information should help with beneficiary and family understanding of potential changes to Medicaid eligibility status, the required beneficiary actions for maintaining Medicaid coverage, and the state process for determining eligibility for another eligibility pathway.

Navigating multiple simultaneous transitions

CYSHCN and their families may experience gaps in coverage because they lack the time needed to complete the Medicaid redetermination while also navigating other benefits program transitions. National and state-level advocates shared that beneficiaries and their families can feel overwhelmed with completing the Medicaid redetermination while they also take steps to enroll in a waiver program and applying for SSI as an adult, and families may need more time to complete all of these enrollment processes. For example, many children with disabilities do not apply for or qualify for SSI until they are an adult (e.g., those enrolled in the Katie Beckett pathway), and interviewees shared that the SSI eligibility determination can sometimes be a multiyear process. If a beneficiary applies for Medicaid while awaiting an SSI disability determination, the state Medicaid agency is required to make its own disability determination if they do not receive one from SSA within 90 days after the Medicaid application submission (42 CFR 435.541). However, state advocates shared that even with these state requirements, delays with the SSI determination can still lead to disruptions in coverage and care for these beneficiaries if they are not eligible for Medicaid through another pathway as an adult. Additionally, those in 1634 states who had SSI as a child and do not qualify for SSI as an adult may be going through the Medicaid redetermination process for the first time as a non-SSI-eligible beneficiary. These beneficiaries, as with any beneficiary being redetermined for Medicaid, may need to provide additional information to the state Medicaid agency to be redetermined on a different basis.

The Medicaid redetermination may also occur simultaneously as the transition from child to adult 1915(c) HCBS waivers, and the outcomes of these two processes may affect each other. Waiver enrollment relies on the beneficiary being enrolled in Medicaid, so if an individual does not complete their redetermination and they lose coverage or the state determines they are not eligible on any other basis, the beneficiary will be disenrolled from the waiver. However, in some cases, waiver enrollment can confer Medicaid eligibility for individuals who would not otherwise be eligible (CMS 2025b). Advocates shared that beneficiaries who are on a 1915(c) HCBS waiver waitlist may be unable to enroll in Medicaid while on the waitlist if they are not eligible for Medicaid on any other basis.

Insufficient support with the Medicaid redetermination

Advocates shared that the level of support (e.g., dedicated case manager or care coordinator) that CYSHCN and their families receive when navigating

the Medicaid redetermination when aging out of child Medicaid varies among states and waivers within states. One of the key components of structured transition plans for those transitioning between pediatric and adult care is having a transition coordinator or a point of contact during this period to help prepare for and support the transition (Gabriel et al. 2017). Findings from our stakeholder interviews indicate that it is also important to have a transition coordinator or dedicated case manager to support families with Medicaid redeterminations. Several state advocates and state officials shared that beneficiaries enrolled in waivers receive support with the Medicaid redetermination from their waiver case managers and that, in general, they have smoother transitions than beneficiaries who are not enrolled in waivers and do not have an assigned case manager. For example, some state advocates shared that case managers often submit the information needed for the Medicaid redetermination on behalf of beneficiaries enrolled in 1915(c) HCBS waivers to ease the redetermination process. Additionally, one interviewee emphasized the importance of beneficiaries having a dedicated case manager to help them prepare for these transitions several years in advance of aging out of child eligibility. The advance planning helps ensure the family is prepared for all of the changes and supports a more seamless coverage transition.

Commission Recommendations

The Commission makes six recommendations to improve Medicaid redeterminations and continuity of coverage for beneficiaries as they transition to adult Medicaid.

Recommendation 5.1

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend 42 CFR 435.919(b)(6) to require states to send a notice a minimum of 60 days in advance of children and youth with special health care needs (CYSHCN) aging out of child Medicaid eligibility to inform them that the renewal process has been initiated. CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

Rationale

Research demonstrates that beneficiaries and families need advance notice of the upcoming transition from child to adult Medicaid so that they are aware of and can prepare for the steps needed to maintain Medicaid coverage as an adult. Without adequate time to prepare, beneficiaries and families may not complete the redetermination process within the allotted time, potentially leading to termination of coverage. For example, in our stakeholder interviews, one state advocate shared that it would help families if the Medicaid agency sent out information about what to expect, such as changes related to eligibility criteria and what information the beneficiary and family may need to provide, so that families can prepare in advance for this process. Additionally, advocates shared that it would be helpful if the notices from state Medicaid agencies could also provide basic information about other determinations that may occur during the same period and affect Medicaid coverage, such as the SSI age-18 redetermination and 1915(c) HCBS waiver enrollment.

Currently, there is no federal requirement for state Medicaid agencies to notify beneficiaries that they are initiating the redetermination process unless the state needs additional information from the beneficiary to complete the redetermination (42 CFR 435.916) or the state identifies information that will lead to termination, reduced benefits, or increases in premiums or cost sharing (42 CFR. 435.952(d)). Federal rules and guidance also do not specify how much lead time is required to initiate this process, but many states initiate the redetermination between 60 and 90 days before the end of the eligibility period (CMS 2024a). Although not required, some states send advance notices to inform beneficiaries about the redetermination process so that they can prepare. For example, one state

shared that they send a notice a year in advance of the end of the beneficiary's eligibility period, and others shared that they send beneficiaries notices one to two months in advance.

In the Commission's view, states should provide beneficiaries with an informational notice about their age-19 Medicaid redetermination as far in advance as practicable before the state begins the beneficiary's age-19 eligibility redetermination to inform beneficiaries and ensure they and their families have sufficient time to prepare for their transition to adult Medicaid coverage.[12] The informational notice should provide the beneficiary and family with information about what to expect as part of the renewal process at age 19, including that they may be asked to provide information to complete the redetermination as an adult. Additionally, the state should write the informational notice in plain language, clearly explain that it requires no action from the beneficiary in advance of the redetermination process, and commit to send a separate request to the beneficiary for information if it needs additional information to complete the redetermination. In establishing rules and subregulatory guidance, CMS should emphasize that sending an informational notice 60 days in advance of the beneficiary turning age 19 is a minimum and encourage states to send these informational notices as early as is feasible. For example, states that already begin this process more than 60 days in advance should notify beneficiaries when they begin the redetermination process.

Implications

Federal spending. The Congressional Budget Office (CBO) estimates this recommendation would not have a direct effect on federal Medicaid spending. CMS would have to commit time and resources to issue guidance related to this new requirement.

States. States would be required to send a new notice to beneficiaries, which may require eligibility system programming changes to develop and generate this type of notice. Additionally, there may be administrative burden to identify CYSHCN and target notices to this population.

Enrollees. This policy may help ensure beneficiaries, their families, and caregivers are more prepared for the Medicaid redetermination at age 19, which may ease the redetermination process and improve continuity of coverage.

Plans. To the extent that an informational notice provided before the renewal eases the beneficiary's Medicaid redetermination process and continuity of coverage as an adult, plans may have fewer beneficiaries who are experiencing disruptions in coverage.

Providers. Transition coordinators and other care and coverage coordinators may also have more advance notice of upcoming redeterminations, which may improve their ability to support beneficiaries. To the extent that the advance notice eases the beneficiary's Medicaid redetermination process and continuity of coverage as an adult, providers may be able to provide care to their beneficiaries with fewer disruptions.

Recommendation 5.2

State Medicaid agencies should provide children and youth with special health care needs (CYSHCN) who are aging out of child Medicaid eligibility with a minimum of 30 days to respond to requests for information to complete Medicaid redeterminations in accordance with 42 CFR 435.919(c)(1). CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

Rationale

Under current rules established in 2024, states are required to implement a 30-day minimum for beneficiaries to respond to requests for information before the state takes an adverse action, including terminating coverage, to ensure beneficiaries have adequate time to respond without overburdening the state (CMS 2024b). However, the 2025 Budget Reconciliation Act prevents CMS from enforcing this requirement but does not eliminate the state option to provide a longer response time. In effect, the pre-2024 policies are restored, and states can opt to implement a 30-day response time.

Research demonstrates that many beneficiaries and their families have challenges with responding to requests for information within the time they are currently given, which may contribute to loss of or gaps in coverage among CYSHCN who are aging out of child Medicaid. For example, currently, 14 states provide beneficiaries with only 10 days to respond to these types of requests (Brooks et al. 2025). In our stakeholder interviews, some advocates shared that beneficiaries may receive their notice too late to respond to within the required time frame, which can lead to delays with the redetermination or termination of coverage. Furthermore, advocates shared that the coverage transition is often just one of many that the family is navigating and that families often feel overwhelmed by the amount of information requests they have to respond to within a short time frame.

States that do not already provide beneficiaries with a minimum of 30 days to respond to requests for information should implement this minimum response time for CYSHCN aging out of child Medicaid eligibility. The Commission emphasized that 30 days is meant to be a minimum, and states are encouraged to allow more time for beneficiaries to respond. The longer response time would ensure beneficiaries, their families, and their caregivers have adequate time to gather any requested information.

Implications

Federal spending. The CBO estimates this recommendation would not have a direct effect on federal Medicaid spending. There is no anticipated effect on CMS, as it does not need to approve these state changes.

States. There would be some administrative burden for states to revise notice procedures and language to accommodate the 30-day response period.

Enrollees. This policy provides beneficiaries, their families, and caregivers more time to submit required information to the state Medicaid agency, which would help them maintain their Medicaid coverage into adulthood.

Plans. Plans may have fewer beneficiaries who are experiencing disruptions in coverage and care.

Providers. We do not anticipate any direct implications for providers. To the extent that providers send beneficiaries requested medical records as part of the Medicaid redeterminations, providers would have more time to complete this process.

Recommendation 5.3

To ensure the accuracy of information provided by the Social Security Administration (SSA) to Medicaid beneficiaries enrolled in Supplemental Security Income (SSI)-related eligibility pathways who are being notified that they are losing eligibility for SSI, the Secretary of the U.S. Department of Health and Human Services, through the Centers for Medicare & Medicaid Services, should coordinate with SSA to review and update model notice language pertaining to Medicaid in SSA's Program Operations Manual System manual paragraphs. The model language should clearly indicate that the individual may retain their Medicaid coverage while the state Medicaid agency takes steps to redetermine the individual on a new basis of eligibility. Additionally, the model language should describe, in general terms, the steps the individual needs to follow to complete the Medicaid redetermination that are specific to 1634, SSI criteria, and 209(b) states.

Rationale

When Medicaid-beneficiaries who were receiving SSI lose SSI eligibility, they receive a notice from SSA, not state Medicaid agencies, about their SSI denial and information about SSI-related Medicaid eligibility (20 CFR 416.1336 and 42 CFR 435.917). Unlike SSA, which is required to send notices to individuals about changes to SSI eligibility and potential effects on Medicaid eligibility, state Medicaid agencies are not required to send a notice to the beneficiary about these changes unless the state needs additional information from the beneficiary to complete the redetermination (42 CFR 435.916) (SSA 2025a). Findings from stakeholder interviews indicate that the information the beneficiary receives from SSA about how a loss of SSI affects Medicaid eligibility is sometimes unclear, leading to beneficiary and family confusion about their Medicaid enrollment status and the steps they need to take to maintain eligibility. For example, national and state-level advocates shared that these notices may not always explain that Medicaid coverage is not immediately terminated or include information about the state Medicaid

agency's general next steps for redetermining Medicaid coverage. This can lead to challenges that are unique for beneficiaries in 1634 states, where SSI eligibility automatically confers Medicaid eligibility and beneficiaries have not had to directly apply to Medicaid for coverage. These beneficiaries may have to send information directly to the state Medicaid agency for an eligibility determination for the first time and may not understand how the redetermination process works.

There are no federal requirements for SSA and CMS to coordinate on the SSA notice language sent to beneficiaries who lose SSI. Given that most beneficiaries only receive a notice from SSA about how a loss of SSI may affect Medicaid eligibility, it is important that the Medicaid eligibility information in this notice is accurate and clear. Currently, the SSA Program Operations Manual System includes template notice language to send to individuals who lose SSI at the age-18 redetermination and specific language for those residing in 1634 and non-1634 states (SSA 2025b, 2011). For example, in 1634 states, where Medicaid eligibility is automatic and beneficiaries do not have to apply to Medicaid separately, these notices specify that these individuals no longer qualify for Medicaid based on SSI rules and that there may be other pathways for Medicaid eligibility. In non-1634 states, the notice language on Medicaid eligibility instructs individuals to contact the state Medicaid agency to determine if they are still eligible for Medicaid (SSA 2011). The template notice language does not include information about continued Medicaid eligibility during the Medicaid redetermination process or information about what the beneficiary should expect during this process, such as how and when they will be contacted by the Medicaid agency.

To ensure Medicaid beneficiaries receive SSA notices that include easily understood and accurate information about how a loss of SSI could affect their Medicaid coverage, CMS should coordinate with SSA on developing model notice language on the effects on Medicaid eligibility. In the development of the model notice language, CMS should seek input from states and advocates to ensure that the model language is accurate and understandable to Medicaid beneficiaries. The model notice language should indicate potential implications for Medicaid coverage so beneficiaries are aware that Medicaid coverage is not immediately terminated. CMS should also coordinate with SSA to develop model template language tailored for the different types of Medicaid determination states (i.e., 1634, SSI criteria, and 209(b)). For example, in 1634 states, the model notice language should specify that Medicaid eligibility is no longer automatic and that the individual will now need to directly communicate with the state Medicaid agency on issues regarding their Medicaid coverage. Furthermore, CMS should consider including language in the notice to describe the general steps of the Medicaid redetermination process and the type of information a beneficiary may need to provide to the state Medicaid agency to complete the redetermination (e.g., household income).

Implications

Federal spending. The CBO estimates this recommendation would not have a direct effect on federal Medicaid spending. CMS would have to commit time and resources to review and update the SSA notice language in partnership with SSA and ensure ongoing coordination with SSA to update notice language to reflect evolving federal Medicaid eligibility and enrollment policies.

States. As part of CMS's efforts to develop model notice language, state Medicaid agencies may be asked to provide input on the notice language to ensure it is accurate and clarifies the effect of a loss of SSI on Medicaid coverage.

Enrollees. This policy would help ensure that beneficiaries, their families, and caregivers have greater clarity about the effect of losing SSI eligibility on Medicaid eligibility and the steps they need to take to ensure that if the beneficiary remains Medicaid eligible, they are able to maintain coverage. To the extent that CMS seeks input from beneficiaries, some beneficiaries may have an opportunity to engage in the development of this model notice language.

Plans. To the extent that improved notice language eases the beneficiary's Medicaid redetermination process and continuity of coverage as an adult, plans may have fewer beneficiaries who are experiencing disruptions in coverage.

Providers. To the extent that improved notice language eases the beneficiary's Medicaid

redetermination process and continuity of coverage as an adult, providers may be able to provide care to their beneficiaries with fewer disruptions.

Recommendation 5.4

State Medicaid agencies should implement optional Medicaid eligibility for children and youth with special health care needs (CYSHCN) up to age 21 who are not otherwise eligible for and enrolled in mandatory coverage or optional full Medicaid coverage under the state plan (42 CFR 435.222 and 42 CFR 435.223). CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under The Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

Rationale

This recommendation is intended to ease the transition from child to adult Medicaid coverage for CYSHCN and improve their coverage stability when aging into adulthood. Recent national and state-level research indicates that Medicaid-covered CYSHCN are at a much higher risk of experiencing disenrollment and short disruptions of coverage when they are aging into adult coverage compared to when they are Medicaid covered as children (Cliff et al. 2026, MACPAC 2026, McMahon et al. 2025, Smith et al. 2025, and McManus et al. 2024). CYSHCN and their families can experience unique challenges with completing the Medicaid redetermination at age 19, as they are also often navigating multiple program transitions (e.g., child-only to adult 1915(c) HCBS waivers, age-18 SSI redetermination), which can overwhelm and overburden families and lead to an increased risk of losing coverage (MACPAC 2025, McManus et al. 2024). Furthermore, many CYSHCN have complex medical conditions and are considered some of the most vulnerable Medicaid-covered children. They rely on specialized pediatric care and continue to need these specialized services as adults, so coverage disruptions are particularly challenging for these children, as accessing their specialized care relies on coverage. As they age into adulthood and are transitioning from a pediatric model of care to the adult care system, maintaining coverage stability is even more important for maintaining continuity of care (Cliff et al. 2026, 2025; Validova et al. 2023; Musumeci and Chidambaram 2019).

Delaying the transition to adult Medicaid coverage is one of many approaches state Medicaid agencies can take to improve coverage stability for CYSHCN who are at risk of disenrolling and becoming uninsured when they age out of child Medicaid. Findings from stakeholder interviews, literature review, and MACPAC's chapter in the June 2025 report to Congress indicate that extending child eligibility to age 21 could benefit CYSHCN and their families in two primary ways (MACPAC 2025). First, delaying this coverage transition would ensure CYSHCN and families, including those who may not be eligible as an adult, have coverage stability while navigating multiple transitions that occur between age 18 and 21. Second, the extended eligibility can act as a bridge between child and adult coverage by providing families with more time to complete transition steps that can directly affect an individual's ability to meet adult Medicaid eligibility criteria. For example, state officials from two states that have extended child eligibility shared that in some cases, additional time is needed so beneficiaries and families can complete the adult SSI application process, which they shared can take multiple years, or determine guardianship for the beneficiary. Without being able to maintain Medicaid through an extended child eligibility pathway, some CYSHCN may experience long- and short-term coverage disruptions, which can be detrimental to their health. Furthermore, interviewed advocates and some states also raised the importance of extending eligibility up to age 21 to align with the EPSDT requirement and other services received outside of Medicaid.

Currently, states have the flexibility to extend Medicaid coverage for children up to age 21 (42 CFR 435.222 and 42 CFR 435.223), and CMS further clarified the use of this pathway in the 2024 E&E final rule (CMS 2024b). Four states have implemented this state option and have established varying eligibility criteria for this extended eligibility pathway (CMS 2023b). For example, all three expansion states must establish a baseline household income that exceeds the

maximum income limit for the expansion pathway (133 percent FPL), so all three states established different household income ranges using 133 percent FPL as their minimum income (upper household income ranges from 150 to 300 percent FPL). Additionally, Maine (an expansion state) specifies that children can enroll in this pathway only if they are not eligible or enrolled in any mandatory or state optional full-benefit pathways (CMS 2023a).

This recommendation directs states to implement this state optional pathway for CYSHCN who are not eligible for or enrolled in another mandatory or state optional pathway under the state plan and would otherwise disenroll when aging out of child Medicaid. The Commission weighed several factors that states should consider when implementing this optional pathway. First, this optional pathway provides states with a number of flexibilities in how it is designed, and states should consider how to implement an extended pathway that best meets the needs of their beneficiaries who are at risk of becoming uninsured at age 19. Second, some Commissioners raised concerns about the state fiscal impact of expanding coverage to individuals who may otherwise disenroll. In the implementation of this state option, states should consider how narrowly or broadly to define the eligibility criteria for this pathway and the effect on the state's budget, especially as states are balancing many other state priorities. On the other hand, there was some discussion of the state fiscal impact of covering health care costs for uninsured individuals, especially for youth with complex medical conditions who are at an increased risk of ED use due to missed care. Estimates of public funding sources for uncompensated care suggest that state and local programs fund about 35.9 percent of these costs (Coughlin et al. 2021).

Implications

Federal spending. The CBO estimates this recommendation would not have a direct effect on federal Medicaid spending. CMS would have to commit time and resources to reviewing state plan amendments.

States. This existing state option gives states the flexibility to determine the eligibility criteria for this optional pathway, including the population, age groups, and household income level. The state budget implications are dependent on how broadly or narrowly a state decides to define these criteria.

Enrollees. The implementation of this policy may allow beneficiaries who would otherwise disenroll at age 19 to remain eligible, if they meet the state's optional pathway eligibility criteria. This extended coverage up to age 21 could also provide families with more time to complete a non-Medicaid transition that could directly affect an individual's ability to meet adult Medicaid eligibility criteria (e.g., applying for SSI as an adult).

Plans. To the extent that this extends coverage and improves continuity of coverage during this transition period, plans may have fewer beneficiaries who are experiencing disruptions in coverage.

Providers. To the extent that states choose to implement this option, CYSHCN who would otherwise disenroll from Medicaid at age 19 would be able to remain Medicaid covered and receive continuous care from their providers.

Recommendation 5.5

To ensure children and youth with special health care needs (CYSHCN) receive a full 12-month continuous eligibility period in their final year of child Medicaid eligibility, Congress should amend § 1902(e)(12) of the Social Security Act to require states to provide CYSHCN with a 12-month continuous eligibility period that lasts a full 12 months from the date of the eligibility determination, even if during the continuous eligibility period, an individual reaches the upper age limit for the eligibility pathway by which they are eligible for Medicaid. This 12-month continuous eligibility period should apply to all CYSHCN who receive coverage from a mandatory or optional child eligibility pathway, including optional pathways covering youth above age 18. CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

Rationale

Findings from our T-MSIS analysis indicate that about 17.6 percent of transition-age youth enrolled in disability-related pathways disenroll when aging out of child eligibility pathways, and of those who disenroll, about one-third churn back onto Medicaid within 12 months. CYSHCN often have complex medical conditions, requiring care coordination and frequent appointments with primary care and specialized providers, and are particularly vulnerable to coverage disruptions (Cliff et al. 2026). Gaps in coverage, even for short periods, are associated with delays in receipt of care, an increase in unmet health needs, fewer office-based doctor visits, an increase in the risk of hospitalization, and higher administrative costs (Rennane et al. 2023, Brantley and Ku 2022, Hemmeter 2011). Additionally, gaps in coverage can lead to increases in health care use after regaining coverage. For example, findings from a 2022 MACPAC study of health care utilization for adults following a gap in coverage show that hospitalization and ED rates were more than twice as high after the churn period as the baseline utilization before disenrollment (MACPAC 2022).

Beginning in 2024, states are required to provide 12 months of continuous eligibility for all children younger than age 19 until the earlier of four events: the individual's 12-month eligibility period ends, the individual attains age 19, the individual requests voluntary disenrollment, or the individual is no longer a resident of such state (Section 1902(e)(12)(A) of the Act). Congress made the continuous eligibility policy mandatory in response to research that showed that continuous eligibility reduces rates of churn and improves access to care and short- and long-term health outcomes for children (CMS 2023c). With the current requirement, beneficiaries remain continuously eligible for 12 months up to age 19 and must be redetermined before reaching the end of the eligibility period upon turning age 19.

This recommendation is intended to address churn among CYSHCN during their transition to adult Medicaid coverage and improve continuity of coverage into adulthood by amending the 12-month continuous eligibility requirement for CYSHCN in two ways. First, the continuous eligibility requirement should be amended so that beneficiaries receive the full 12-months of continuous eligibility, even if during the continuous eligibility period the CYSHCN reaches their eligibility pathway's upper age limit, rather than having the continuous eligibility period end when an individual attains the eligibility period's upper age limit. This change aligns with the state option to extend 12-month postpartum coverage, which ensures that those eligible for 12 months of postpartum coverage continue to receive continuous eligibility even if the postpartum period extends beyond the regularly scheduled renewal date (CMS 2021). Additionally, this policy applies to those who age out of an eligibility pathway. For example, for Medicaid- and CHIP-covered pregnant individuals younger than age 19, the 12-month postpartum coverage period would apply even if the beneficiary turns age 19 and extend beyond the eligibility pathway's upper age limit (CMS 2021). Second, the continuous eligibility requirement should apply to child eligibility pathways that extend beyond age 18 to account for some states' extension of child coverage. Under current requirements, states are not permitted to provide 12 months of continuous eligibility to children after age 18, even if children are enrolled in a child eligibility pathway that extends up to age 21.

In considering this recommendation, the Commission discussed the importance of continuity of coverage for this population and weighed several factors in amending the current 12-month continuous eligibility requirement for children. CYSHCN transitioning to adulthood navigate many simultaneous program transitions between age 18 and 21, and providing 12 months of continuous eligibility in the final year of child eligibility could reduce beneficiary and family burden with completing multiple redeterminations. Additionally, this recommendation could improve continuity of coverage into adulthood, including for those enrolled in state optional pathways that extend child eligibility up to age 21, and reduce the risk of adverse health outcomes due to gaps in coverage. Commissioners raised that there are financial implications related to churn and policies that aim to reduce it. For example, a number of studies show that churning may increase overall Medicaid costs for beneficiaries of all ages due to pent-up demand for care and increased ED use after gaps in coverage (Sugar et al. 2021). Furthermore, some studies have shown that churn can lead to increases in state Medicaid agency administrative costs due to additional redeterminations

and renewals (Sugar et al. 2021). However, some studies raised that policies to reduce churn, such as providing 12 months or longer CE to children, have been shown to increase federal and state costs because of increased enrollment and potentially covering individuals who are no longer eligible for Medicaid (CBO 2024, Buettgens 2023).

Implications

Federal spending. The CBO estimates this recommendation would increase federal direct spending between $250 million and $2 billion.

States. This policy would require states to provide CYSHCN with 12 months of continuous eligibility through the end of the child's eligibility pathway's upper age limit, which extends the number of months that states cover these children under a child mandatory or optional state pathway. In states that have extended Medicaid coverage to individuals up to age 20 or 21, they would now also be required to provide CYSHCN covered under this optional pathway with 12 months of continuous eligibility.

Enrollees. This policy may reduce administrative burden in the final 12 months before aging out of child Medicaid by having the continuous eligibility period continue for 12 months, even if it extends beyond age 19. Additionally, those covered under a state optional pathway that extends Medicaid coverage to individuals up to age 20 or 21 will receive 12 months of continuous eligibility through the end of the eligibility pathway's upper age limit.

Plans. To the extent that this improves continuity of coverage during this transition period, plans may have fewer beneficiaries who are experiencing disruptions in coverage and care.

Providers. To the extent that CYSHCN are less likely to disenroll or churn during this transition period, they will be able to remain connected to and receive continuous care from their providers.

Recommendation 5.6

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance to states on existing authorities for supporting children and youth with special health care needs (CYSHCN) with Medicaid redeterminations and transitioning to adult Medicaid coverage. The guidance should address authorities to cover case management, transition planning for child-only Section 1915(c) home- and community-based services waivers, and the state optional pathway to cover children up to age 21. CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

Rationale

Findings from the stakeholder interviews demonstrate that many young adults transitioning to adult Medicaid coverage do not receive sufficient support with navigating the Medicaid eligibility redetermination at age 19. For example, interviewees shared that many CYSHCN need a dedicated case manager or care coordinator to explain the steps needed to complete the financial and disability determinations at age 19, when most beneficiaries are redetermined as an adult. Several state advocates and state officials shared that, in general, beneficiaries enrolled in child-only 1915(c) HCBS waivers who have a dedicated case manager receive support with preparing for the Medicaid financial eligibility redetermination and waiver functional eligibility assessments years in advance and have smoother transitions to adult Medicaid than beneficiaries who are not enrolled in these waivers. However, the level of support with both the Medicaid redetermination and the transition to adult 1915(c) HCBS waivers that beneficiaries enrolled in child-only 1915(c) HCBS waivers receive can vary among states and even between state waiver programs because there may not be enough staff to support all families through these multiple transition processes.

Currently, there is no CMS guidance to states on existing authorities and flexibilities that are specific to how states can ease CYSHCN transitions to adult coverage. In the Commission's view, in developing the guidance, CMS should at minimum address the following:

- authorities states can use to provide CYSHCN with a dedicated case manager or care coordinator to support them with understanding the steps needed to complete the financial and disability determinations that need to be completed for the age-19 Medicaid redetermination (e.g., TCM, case management through a 1915(c) HCBS waiver);
- transition planning procedures states can include in state age-limited Section 1915(c) HCBS waivers to support beneficiaries and their families through the Medicaid redetermination process (e.g., support with preparing for the upcoming redetermination as an adult, understanding how the adult eligibility criteria may differ from those for children, and preparing the beneficiary and family for what information they may need to provide the state Medicaid agency); and
- implementation of the state option to extend child eligibility up to age 21 under 42 CFR 435.222 or 42 CFR 435.223 and examples of how states have implemented this optional pathway (e.g., reasonable classifications of individuals younger than age 21 that states have chosen for this pathway, income eligibility criteria) and the potential state financial implications of covering these children.

Additionally, CMS may wish to consider addressing other state options to ease transitions, including providing a 90-day reconsideration period for non-MAGI beneficiaries, in the guidance. States are required to provide beneficiaries eligible under MAGI rules, and have the option to provide other beneficiaries, with a 90-day reconsideration period for those who have Medicaid terminated due to failure to provide information (42 CFR 435.916(b)(2)(iii) and 42 CFR 435.919(d)). If beneficiaries send the information within 90 days, their Medicaid eligibility would be back dated to the date that coverage was terminated (CMS 2024d). The 2024 E&E final rule requires states to implement a 90-day reconsideration period for non-MAGI beneficiaries as well, but this provision was paused through 2035, so the requirement is not enforceable by CMS (2025 Budget Reconciliation Act).[13]

Implications

Federal spending. The CBO estimates this recommendation would not have a direct effect on federal Medicaid spending. CMS would have to commit time and resources to issuing guidance.

States. The guidance will provide states with greater clarity on the available existing authorities to support CYSHCN transitions to adult Medicaid.

Enrollees. This policy may improve beneficiary and family support with Medicaid redeterminations and the transition to adult Medicaid coverage.

Plans. There may be administrative effort for plans to develop payment policy and guidance for providers supporting beneficiaries with Medicaid redeterminations.

Providers. To the extent that states choose to provide support to CYSHCN with the Medicaid redetermination through managed care organizations, providers may engage in supporting CYSHCN with the transition to adult Medicaid coverage.

Looking Ahead

Over the past two analytic cycles, the Commission focused on CYSHCN and their coverage and care transitions as they age into adulthood. This work culminated in two chapters published in the June 2025 and 2026 reports to Congress with a total of 10 recommendations for improving CYSHCN transitions and their continuity of care and coverage. Looking ahead, we are continuing our commitment to building our body of work on access to coverage and care for CYSHCN, including forthcoming work focused on those with complex behavioral health needs and those involved in the child welfare system.

Endnotes

[1] In 2024, MCHB broadened its approach to screening for CYSHCN as part of the National Survey of Children's Health. The expanded definition of CYSHCN includes those who are identified by the screener and those who did not qualify based on the screener but have at least one health condition and functional difficulty. This expanded approach increases the national percentage of CYSHCN by about 5 percent (DRC 2025, Black et al. 2024).

[2] MCBH funds state Title V programs through the Maternal and Child Health Services Block Grant Program. The purpose of this program is to address health service needs and improve the health and well-being of women, children (including CYSHCN), and families through family-centered and community-based efforts (Honsberger et al. 2018, NASHP 2018). The Health Resources & Services Administration (HRSA) requires state Title V programs to use at least 30 percent of the Title V Block Grant funds to provide and improve services for CYSHCN (MCHB 2024, Platt et al. 2020). State Title V programs use these funds to provide direct care (e.g., primary care), enabling services (e.g., care coordination), and public health services and systems (e.g., activities and infrastructure support).

[3] States can use a number of authorities to cover children with disabilities whose family income may be too high to qualify for Medicaid through other eligibility pathways, and states may refer to programs by a variety of names. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established the optional Katie Beckett state plan pathway for children with disabilities. This pathway allows states to cover children with severe disabilities whose family income may otherwise be too high to qualify for Medicaid through their state plan. Only the child's own income and assets are counted (42 CFR 435.225). In addition, some states provide similar services to the same population under Section 1915(c) waivers rather than under the state plan. However, unlike the TEFRA state plan option, states that serve this population under a Section 1915(c) waiver can limit the number of waiver slots (MACPAC 2023, Colello and Morton 2019, CISWH 2016). As of 2022, 43 states and the District of Columbia use the Katie Beckett eligibility pathway or have a comparable 1915(c) waiver (Musumeci et al. 2022).

[4] State Medicaid programs can cover children with disabilities younger than age 19 whose family income may otherwise be too high to qualify for Medicaid or SSI through the optional TEFRA state plan pathway, which is also referred to as the Katie Beckett state plan option, or under Section 1915(c) HCBS authority. The Katie Beckett state plan pathway uses the SSI definition of disability and counts only the child's income and assets (42 CFR 435.225). The Katie Beckett state plan option allows these children to receive services in their home and affords greater employment flexibility to beneficiary families (Colello and Morton 2019, CISWH 2016). Some states provide similar services to the same population under Section 1915(c) HCBS waivers rather than under the state plan.

[5] To qualify for SSI, children and adults are required to meet federal medical and financial criteria, which include income and asset limits, and the disability criteria are different for children and adults. To be eligible for SSI as a child, they must have "a medically determinable physical or mental impairment which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." As an adult, the disability criteria are instead based on their ability to perform work at a substantial gainful activity level (Hemmeter et al. 2009). This is defined based on monthly earnings, and this amount is defined based on the nature of a person's disability and is adjusted with changes in the national average wage index (SSA n.d.a).

[6] This new waiver option will be available to states on July 1, 2028, and may provide beneficiaries with another pathway to Medicaid eligibility and access to additional services not covered under the state plan (CMS 2025a).

[7] The resource limit for SSI was set in 1972 and was not indexed to inflation, so the resource limit is currently only one-sixth of the 1972 value. The limits contribute to rates of churn and rates of ineligibility (Romig et al. 2023).

[8] As of 2023, the District of Columbia, Florida, Maine, and Massachusetts have adopted this option and cover beneficiaries age 19 and 20 (CMS 2023c).

[9] In 2024, CMS's E&E final rule added 42 CFR 435.223 to clarify that states can extend coverage for individuals younger than age 21 who meet the criteria for non-MAGI eligibility groups (CMS 2024b). The reasonable classifications of individuals younger than age 21 are those described in any clause of Section 1902(a)(10)(A)(ii) of the Act.

[10] HRSA administers family-to-family health information centers, and some of these centers provide one-on-one transition guidance or support. These centers are staffed by individuals with lived experience, so they can be particularly

helpful to families navigating complex health-related challenges, including transitions to adult care (HRSA 2024).

[11] Functional eligibility is determined using an assessment tool, and generally, individuals must be found to have an institutional level of care (LOC) to qualify for an HCBS waiver. An LOC assessment is used to determine what services a beneficiary needs while on the waiver, and this assessment is completed annually. Functional assessments are often completed by the agency that oversees the waiver or a third-party vendor, who shares the results with the state Medicaid agency (MACPAC 2016).

[12] We define an informational notice as information sent to the beneficiary to prepare them for the upcoming redetermination that requires no action from the beneficiary. This type of informational notice is different from a notice, as defined in 42 CFR 431.210, or an advance notice, as defined in 431.211, which is required when the state is taking an action under 431.206(c).

[13] Before the 2024 E&E final rule, states were required to provide beneficiaries under MAGI rules with a 90-day reconsideration period and had the option to provide this same reconsideration period to non-MAGI beneficiaries (CMS 2024b).

References

Alker, J., A. Osorio, T. Brooks, and E. Park. 2024. *Child Medicaid disenrollment data shows wide variation in state performance as continuous coverage pandemic protections lifted.* Washington, DC: Center for Children and Families, Georgetown University McCourt School of Public Policy. https://ccf.georgetown.edu/2024/05/02/child-medicaid-disenrollment-data-shows-wide-variation-in-state-performance-as-continuous-coverage-pandemic-protections-lifted/.

Black, L.I., R.M. Ghandour, J.P. Brosco, et al. 2024. An expanded approach to the ascertainment of children and youth with special health care needs. *Pediatrics* 153, no. 6: e2023065131. https://publications.aap.org/pediatrics/article/153/6/e2023065131/197244/An-Expanded-Approach-to-the-Ascertainment-of.

Brantley, E., and L. Ku. 2022. Continuous eligibility for Medicaid associated with improved child health outcomes. *Medical Care Research and Review* 79, no. 3: 404–413. https://pubmed.ncbi.nlm.nih.gov/34525877/.

Brooks, T., J. Tolbert, A. Mudumala, et al. 2025. *Medicaid and CHIP eligibility, enrollment, and renewal policies as states resume routine operations: Following the unwinding of the pandemic-era continuous enrollment provision.* Washington, DC: KFF. https://www.kff.org/medicaid/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-resume-routine-operations-following-the-unwinding-of-the-pandemic-era-continuous-enrollment-provision/.

Buettgens, M. 2023. *Ensuring continuous eligibility for Medicaid and CHIP: Coverage and cost impacts for adults*. Washington, DC: The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/ensuring-continuous-eligibility-medicaid-impacts-adults.

Center for Innovation in Social Work & Health (CISWH), Boston University School of Social Work. 2016. *The TEFRA Medicaid state plan option and Katie Beckett waiver for children—making it possible to care for children with significant disabilities at home.* Boston, MA: CISWH. https://ciswh.bu.edu/wp-content/uploads/2025/06/TEFRA.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2025a. Center for Medicaid & CHIP Services information bulletin regarding "'Working Families Tax Cut' legislation, Public Law 119-21: Summary of Medicaid and Children's Health Insurance Program (CHIP) related provisions." November 18, 2025. https://www.medicaid.gov/federal-policy-guidance/downloads/cib11182025.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2025b. State Medicaid plans and waivers. Baltimore, MD: CMS. https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/ltss-ta-center/information/state-medicaid-plans-and-waivers.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024a. Centers for Medicaid & CHIP Services informational bulletin regarding "Basic requirements for conducting *ex parte* renewals of Medicaid and CHIP eligibility." November 26, 2024. https://www.medicaid.gov/federal-policy-guidance/downloads/cib11262024.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024b. Medicaid program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program application, eligibility determination, enrollment, and renewal

processes. Final rule. *Federal Register* 89, no. 64 (April 2): 22780–22878. https://www.govinfo.gov/content/pkg/FR-2024-04-02/pdf/2024-06566.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024c. *Instructions, technical guide, and review criteria.* Baltimore, MD: CMS. https://wms-mmdl.cms.gov/WMS/faces/portal.jsp.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024d. Center for Medicaid & CHIP Services informational bulletin regarding "Conducting Medicaid and CHIP renewals during the unwinding period and beyond: Essential reminders." March 15, 2024. Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/cib03152024.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023a. Maine state plan amendment no. 23-0017 approval letter, summary form, and approved SPA pages. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/spa/downloads/ME-23-0017.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023b. Medicaid, Children's Health Insurance Program, & Basic Health Program eligibility levels. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023c. Letter from Daniel Tsai to state health officials regarding "Section 5112 requirement for all states to provide continuous eligibility to children in Medicaid and CHIP under the Consolidated Appropriations Act, 2023." September 29, 2023. https://www.medicaid.gov/federal-policy-guidance/downloads/sho23004.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021. Letter from Daniel Tsai to state health officials regarding "Improving maternal health and extending postpartum coverage in Medicaid and the Children's Health Insurance Program (CHIP)." December 7, 2021. https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014. Massachusetts state plan amendment no. 13-009 approval letter, CMS 179 form, and approved SPA pages. March 27, 2014. Baltimore, MD: CMS. https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MA/MA-13-009.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013a. District of Columbia state plan amendment no. 13-07MM approval letter, summary form, and approved SPA pages. November 20, 2013. Baltimore, MD: CMS. https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/DC/DC-13-07-MM.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013b. Medicaid eligibility: Reasonable classification of individuals under age 21. Baltimore, MD: CMS. https://ahca.myflorida.com/content/download/7815/file/S52_CMS_Approval_FL-13-0015-MM1-2.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. n.d. Implementation guide: Medicaid state plan eligibility: Eligibility groups—options for coverage: Reasonable classifications of individuals under age 21. Baltimore, MD: CMS. https://www.medicaid.gov/resources-for-states/downloads/macpro-ig-reasonable-classifications-individuals-under-age21.pdf.

Cliff, B.Q., S. Sinha, D.A. Cross, et al. 2026. Medicaid disenrollment among young adults with and without complex medical conditions. *JAMA Pediatrics*. Published online February 16, 2026. https://doi.org/10.1001/jamapediatrics.2025.6326.

Cliff, B.Q., S. Sinha, D.A. Cross, et al. 2025. Prevalence of complex medical conditions among teens and young adults in Medicaid: National and state estimates. *Journal of Adolescent Health* 77, no. 2: 308–315. https://www.sciencedirect.com/science/article/pii/S1054139X25001570.

Colello, K.J., and W.R. Morton. 2019. *Medicaid eligibility: Older adults and individuals with disabilities.* Washington, DC: Congressional Research Service. https://www.congress.gov/crs-product/R46111.

Congressional Budget Office (CBO). 2024. *Extending Medicaid and CHIP coverage for children: Long-run budgetary effects of the president's 2025 budget proposal*. Washington, DC: CBO. https://www.cbo.gov/publication/61110#.

Coughlin, T.A., H. Samuel-Jakubos, and R. Garfield. 2021. *Sources of payment for uncompensated care for the uninsured*. Washington, DC: KFF. https://www.kff.org/affordable-care-act/sources-of-payment-for-uncompensated-care-for-the-uninsured/.

Data Resource Center for Child & Adolescent Health (DRC), The Child & Adolescent Health Measurement Initiative. 2025. *Title V national performance measure, national outcome measure, and standardized measure changes in the National Survey of Children's Health (NSCH)*. https://www.childhealthdata.org/docs/default-source/nsch-docs/npm-and-nom-changes_2016-2024_cahm_drc.pdf.

Erzouki, F. 2025. *Medicaid eligibility and enrollment rules lay framework for program improvements states can still adopt, despite moratorium*. Washington, DC: Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/medicaid-eligibility-and-enrollment-rules-lay-framework-for-program-improvements.

Gabriel, P., M. McManus, K. Rogers, and P. White. 2017. Outcome evidence for structured pediatric to adult health care transition interventions: A systematic review. *The Journal of Pediatrics* 188: 263–269. https://www.sciencedirect.com/science/article/abs/pii/S002234761730759X.

Health Resources & Services Administration (HRSA). 2024. Family-to-Family (F2F) health information centers. Rockville, MD: HRSA. https://mchb.hrsa.gov/programs-impact/programs/f2f-health-information-centers.

Hemmeter, J. 2011. Health‐related unmet needs of Supplemental Security Income youth after the age‐18 redetermination. *Health Services Research* 46, no. 4: 1224–1242. https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1475-6773.2011.01246.x.

Hemmeter, J., J. Kauff, and D. Wittenburg. 2009. Changing circumstances: experiences of child SSI recipients before and after their age-18 redetermination for adult benefits. *Journal of Vocational Rehabilitation* 30, no. 3: 201–221. https://journals.sagepub.com/doi/10.3233/JVR-2009-0462.

Honsberger, K., B. Wirth, and K. VanLandeghem. 2018. *State strategies to leverage Medicaid and Title V programs to improve care for children with special health care needs in Medicaid managed care*. Portland, ME: National Academy for State Health Policy. https://nashp.org/wp-content/uploads/2018/04/State-Strategies-to-Leverage-Medicaid-and-Title-V-Programs-to-Improve-Care-for-Children-with-Special-Health-Care-Needs-in-Medicaid-Managed-Care.pdf.

Horne, G., A. Gautam, D. Tumin. 2022. Short- and long-term health consequences of gaps in health insurance coverage among young adults. *Population Health Management* 25, no. 3: 399–406. https://journals.sagepub.com/doi/abs/10.1089/pop.2021.0211.

Machledt, D. 2024. How Medicaid work requirements hurt people with disabilities. Washington, DC: National Health Law Program. https://healthlaw.org/resource/unfit-to-work-how-medicaid-work-requirements-hurt-people-with-disabilities-2/.

Maternal & Child Health Bureau (MCHB), Health Resources & Services Administration (HRSA). 2025. Children and youth with special health care needs (CYSHCN). Rockville, MD: HRSA. https://mchb.hrsa.gov/programs-impact/focus-areas/children-youth-special-health-care-needs-cyshcn.

Maternal & Child Health Bureau (MCHB), HRSA. 2024. Title V Maternal and Child Health (MCH) Services Block Grant. Rockville, MD: HRSA. https://mchb. hrsa.gov/programs-impact/title-v-maternal-child-health-mch-services-block-grant.

McMahon, M.V., M.J. Okumura, S.L. Toomey, et al. 2025. Insurance gaps at age‐19 and age‐26 health insurance eligibility thresholds by childhood‐onset condition severity, Colorado 2014–2018. *Health Services Research* 60, no. 2: e14432. https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.14432.

McManus, M.A., S. Ilango, P. White, and A. Schmidt. 2024. *A national report: Youth and young adults with disabilities aging out of Medicaid, CHIP, SSI, and Title V programs—barriers, inequities, and recommendations.* Washington, DC: The National Alliance to Advance Adolescent Health. https://lpfch.org/resource/a-national-report-aging-out/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2026. *CYSHCN transitions to adult Medicaid coverage*. Washington, DC: MACPAC. https://www.macpac.gov/publication/transitions-to-adult-medicaid-coverage-for-children-and-youth-with-special-health-care-needs/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2025. Chapter 1: Children and youth with special health care needs transitions of care. In *Report to Congress on Medicaid and CHIP*. June 2025. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2025/06/MACPAC_June-2025-Chapter-1.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2024. *Access in brief: Children and youth with special health care needs*. Washington, DC: MACPAC. https://www.macpac.gov/publication/access-in-brief-children-and-youth-with-special-health-care-needs-2/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2023. Chapter 4: Access to home- and community-based services. In *Report to Congress on Medicaid and CHIP*. June 2023. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2023/06/Chapter-4-Access-to-Home-and-Community-Based-Services.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022. Updated analyses of churn and coverage transitions. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2022/04/Churn-and-Coverage-Transitions.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016. Chapter 4: Functional assessments for long-term services and supports. In *Report to Congress on Medicaid and CHIP*. June 2016. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2016/06/Functional-Assessments-for-Long-Term-Services-and-Supports.pdf.

Musumeci, M., C. Murphy, E. Leiser, et al. 2025. Reducing Medicaid churn: Policies to promote stable health coverage and access to care. *Issue Briefs*. June 11. New York, NY: The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2025/jun/reducing-medicaid-churn-policies-promote-stable-health-coverage.

Musumeci, M., M. O'Malley Watts, M. Ammula, and A. Burns. 2022. *Medicaid financial eligibility in pathways based on old age or disability in 2022: Findings from a 50-state survey.* Washington, DC: KFF. https://www.kff.org/report-section/medicaid-financial-eligibility-in-pathways-based-on-old-age-or-disability-in-2022-findings-from-a-50-state-survey.

Musumeci, M., and P. Chidambaram. 2019. *Medicaid's role for children with special health care needs: A look at eligibility, services, and spending.* Washington, DC: KFF. https://files.kff.org/attachment/Medicaid%E2%80%99s-Role-for-Children-with-Special-Health-Care-Needs-A-Look-at-Eligibility,-Services-and-Spending.

National Academy for State Health Policy (NASHP). 2018. How state Medicaid and Title V partnerships improve care for children with special health care needs in Medicaid managed care. NASHP: Portland, ME. https://nashp.org/how-state-medicaid-and-title-v-partnerships-improve-care-for-children-with-special-health-care-needs-in-medicaid-managed-care/.

Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2013. Modified adjusted gross income (MAGI) income conversion methodologies. Washington, DC: ASPE. https://aspe.hhs.gov/reports/modified-adjusted-gross-income-magi-income-conversion-methodologies-0.

Okumura, M.J., D.Z. Kuo, A.N. Ware, et al. 2022. Improving health care transitions for children and youth with special health care needs. *Academic Pediatrics* 22, no. 2: S7–S13. https://www.sciencedirect.com/science/article/pii/S1876285921001522.

Platt, T., E. Fernandez, K. Honsberger, and K. VanLandeghem. 2020. *The role of state Medicaid and Title V program definitions of children and youth with special health care needs in the provision of services and supports*. Boston, MA: The Catalyst Center. https://ciswh.bu.edu/wp-content/uploads/2025/06/Brief_Definitions-of-CYSHCN_Medicaid-Title-V-Programs.pdf.

Rennane, S., D. Sobol, B.D. Stein, and A. Dick. 2023. Insurance coverage during transitions: Evidence from Medicaid automatic enrollment for children receiving supplemental security income. *Health Services Research* 59, no. 3: e14261. https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.14261.

Romig, K., L. Nuñez, and A. Sherman. 2023. *The case for updating SSI asset limits: Raising or eliminating limits would reduce administrative burdens without dramatically increasing enrollment*. Washington, DC: Center on Budget and Policy Priorities. https://www.cbpp.org/sites/default/files/6-26-23socsec.pdf.

Saraswathula, V., and K.J. Colello. 2025. *Medicaid Section 1915(c) home- and community-based services waivers*. Washington, DC: Congressional Research Service. https://www.congress.gov/crs_external_products/R/PDF/R48519/R48519.1.pdf.

Schiff, J., L. Manning, K. VanLandeghem, et al. 2022. Financing care for CYSHCN in the next decade: Reducing burden, advancing equity, and transforming systems. *Pediatrics* 149, suppl. 7. https://doi.org/10.1542/peds.2021-056150I.

Smith, R.B., G. Aboulafia, and B.D. Sommers. 2025. Who enrolls in coverage and who remains uninsured? Medicaid take up before and after the Affordable Care Act and during unwinding. *The Milbank Quarterly*. In press. https://dash.harvard.edu/server/api/core/bitstreams/6f09948f-31c6-46e4-baa1-77ba84558e3f/content.

Social Security Administration (SSA). 2025a. Understanding Supplemental Security Income Social Security notices and letters—2025 edition. Baltimore, MD: SSA. https://www.ssa.gov/ssi/text-notices-ussi.htm.

Social Security Administration (SSA). 2025b. DI 23570.030 Disability Determination Services (DDS) procedures for documenting an age-18 redetermination and disabled child (DC) disability determination. Baltimore, MD: SSA. https://secure.ssa.gov/apps10/poms.nsf/lnx/0423570030#.

Social Security Administration (SSA). 2024a. DI 11070.006 Supplemental Security Income (SSI) recipient's ages 14–17 transitioning into adulthood. Baltimore, MD: SSA. https://secure.ssa.gov/poms.nsf/links/0411070006.

Social Security Administration (SSA). 2024b. 2024 annual report of the SSI program: Table V.D4. Baltimore, MD: SSA. https://www.ssa.gov/OACT/ssir/SSI24/V_D_Redet_CDRdata.html#526729.

Social Security Administration (SSA). 2023. Disability evaluation under Social Security: Part 1—general information. Baltimore, MD: SSA. https://www.ssa.gov/disability/professionals/bluebook/general-info.htm.

Social Security Administration (SSA). 2022. DI 23570.100 Age 18 notice of disability redetermination—CDR to disability redetermination—exhibit. Baltimore, MD: SSA. https://secure.ssa.gov/poms.nsf/lnx/0423570100.

Social Security Administration (SSA). 2011. NL 00804.110 Medicaid—SSI paragraphs. Baltimore, MD: SSA. https://secure.ssa.gov/poms.nsf/lnx/0900804110#:~:text=Since%20(you)%20are%20not%20eligible,people%20there%20answer%20your%20questions.&text=Paragraphs%201142%20and%201144%20do%20not%20apply.

Social Security Administration (SSA). 2001. Childhood disability: Supplemental Security Income program. Baltimore, MD: SSA. https://www.ssa.gov/disability/professionals/childhoodssi-pub048.htm.

Social Security Administration (SSA). n.d.a. Substantial gainful activity. Baltimore, MD: SSA. https://www.ssa.gov/oact/cola/sga.html.

Social Security Administration (SSA). n.d.b. Social Security Administration Supplemental Security Income important information. Baltimore, MD: SSA. https://secure.ssa.gov/apps10/public/pomsimages.nsf/gfx_num/G-DI_11070.006C-5/$File/G-DI_11070.006C-5.pdf.

Steinway, C., J. Gable, and S. Jan. 2017. *Transitioning to adult care: Supporting youth with special health care needs*. Philadelphia, PA: PolicyLab. https://policylab.chop.edu/sites/default/files/pdf/publications/Transitions_Of_Care.pdf.

Sugar, S., C. Peters, N. De Lew, and B.D. Sommers. 2021. *Medicaid churning and continuity of care: Evidence and policy considerations before and after the COVID-19 pandemic*. Washington, DC: Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf.

Validova, A., D. Strane, M. Matone, et al. 2023. Underinsurance among children with special health care needs in the United States. *JAMA Network Open* 6, no. 12: e2348890. https://doi.org/10.1001/jamanetworkopen.2023.48890.

White, P.H., W.C. Cooley, Transitions Clinical Report Authoring Group, et al. 2018. Supporting the health care transition from adolescence to adulthood in the medical home. *Pediatrics* 142, no. 5: e20182587. https://publications.aap.org/pediatrics/article/142/5/e20182587/38577/Supporting-the-Health-Care-Transition-From.

APPENDIX 5A: Transformed Medicaid Statistical Information System (T-MSIS) Methods and Findings

MACPAC worked with Acumen to examine data from the Transformed Medicaid Statistical Information System (T-MSIS) for calendar years 2017 through 2019. To observe changes in coverage and disenrollment, we used data from the years before the COVID-19 public health emergency (2020–2023), when states paused Medicaid redeterminations.[1] The analytic population includes transition-age Medicaid children enrolled in a disability-related eligibility group code, using their last-best month in 2017, and were enrolled for all previous 12 months.[2,3] This includes children who were enrolled in multiple eligibility pathways across the 12-month period. For the analysis, we grouped children into three groups: "SSI-related pathways," "other SSI-related pathways, and "other disability-related pathways" (Appendix 5A, Table 5A-1). Transition age is defined as children within 12 months of aging out of child Medicaid eligibility. In most states this age is 19, but four states (the District of Columbia, Florida, Maine, and Massachusetts) have extended child eligibility to age 21 through a state plan option (42 CFR 435.222 and 42 CFR 435.223). We excluded beneficiaries who were not enrolled in a disability-related eligibility group as a child, who were missing an eligibility group code, and who moved to another state between January 2018 and December 2019 from the analytic population.

Using this analytic population, we calculated the number eligible on the basis of disability aging out of child Medicaid eligibility; the percentage who remained Medicaid covered continuously for 12 months after aging out of child Medicaid and transitioning to adult Medicaid coverage; the percentage who disenrolled and remained disenrolled for 12 months; the percentage who disenrolled and reenrolled (churned) within 12 months after aging out; and for those who churned, the average number of months they experienced a gap in coverage. The analysis also identified the adult eligibility pathway for those who remained enrolled as an adult or churned. The adult eligibility group is determined using the individual's eligibility group in the first month of enrollment after the transition. If the eligibility group was different than the one they were enrolled in as a child, they were grouped in one of four categories (adults, modified adjusted gross income (MAGI); adults, non-MAGI, disabled; adults, non-MAGI, non-disabled; and other) (Table 5A-1). Additionally, in states that have adopted the Medicaid expansion pathway, we identified the number that enrolled in this specific MAGI pathway as an adult. Furthermore, for those who churned, the analysis calculated the average number of months between disenrollment and reenrollment.

TABLE 5A-1. Child and Adult Eligibility Pathway Eligibility Group Assignment

Types of eligibility pathways	Eligibility category	Eligibility pathways
Child eligibility pathways	SSI-related	Individuals receiving SSI; aged, blind and disabled individuals in 209(b) states; individuals receiving mandatory state supplements; optional state supplement recipients—1634 states and SSI criteria states with 1616 agreements; and optional state supplement recipients—209(b) and SSI criteria states without 1616 agreements.
	Other SSI-related	Institutionalized individuals continuously eligible since 1973; individuals who lost eligibility for SSI/SSP due to an increase in OASDI benefits in 1972; individuals who would be eligible for SSI/SSP but for OASDI COLA increases since April 1977; and disabled widows and widowers ineligible for SSI, working disabled under 1619(b).
	Other disability-related	Qualified disabled children under age 19; Family Opportunity Act children with disabilities; individuals eligible for HCBS; and medically needy children, parents, and caretakers and aged, blind, and disabled individuals.
Adult eligibility pathways	MAGI	Expansion pathway; transitional medical assistance; extended Medicaid; and pregnant women.
	Non-MAGI, disabled	SSI pathways; other disability pathways that overlap with those listed for child eligibility pathways; essential spouses; blind or disabled eligible in 1973; disabled adult children; qualified Medicare beneficiaries; qualified disabled and working individuals; aged, blind, or disabled individuals eligible for but not receiving cash assistance; ticket to work, individuals eligible for HCBS; and medically needy aged, blind, or disabled.
	Non-MAGI, non-disabled	Certain individuals needing treatment for breast or cervical cancer and medically needy parents and other caretakers.
	Other	Any other adult eligibility pathway.

Notes: SSI is Supplemental Security Income. SSP is state supplemental payment. OASDI is Old-Age, Survivors, and Disability Insurance. COLA is cost-of-living adjustment. HCBS is home- and community-based services. MAGI is modified adjusted gross income. The 1616 agreements are agreements state Medicaid agencies may have under section 1616 of the Social Security Act with the Social Security Administration (SSA) to have SSA administer the state Medicaid agency's supplementary payment programs (CMS n.d.). Child and adult eligibility groups were categorized using similar methods as other recent churn analyses using Transformed Medicaid Statistical Information System (T-MSIS) (Mann et al. 2022, MACPAC 2021). The child eligibility groups were based on age criteria (up to age 19).

Source: MACPAC analysis of T-MSIS, 2017–2019.

T-MSIS findings

The tables and figures below present findings from the analysis of the 2017 through 2019 T-MSIS eligibility and enrollment data referenced in the chapter. Additional findings are published in the 2026 MACPAC issue brief CYSHCN Transitions to Adult Medicaid Coverage (MACPAC 2026).

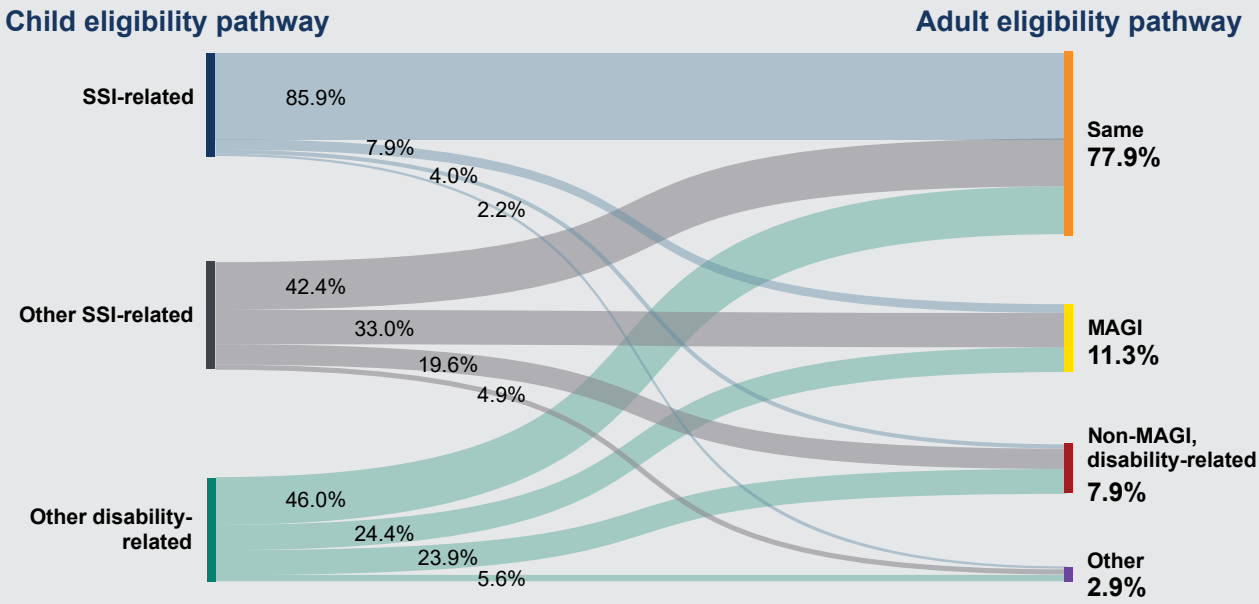
TABLE 5A-2. Disenrollment and Churn When Transitioning to Adult Medicaid Coverage among Transition-Age Children and Youth with Special Health Care Needs by Eligibility Group, 2017–2019

	Transition-age CYSHCN		Disenrolled after aging out of child Medicaid		Churned within 12 months		Disenrolled after aging out of child Medicaid and remain disenrolled for the following 12 months	
Eligibility group	Number of transition-age CYSHCN	Share who remained continuously enrolled	Number of transition-age CYSHCN	Share of all transition-age CYSHCN	Share of all transition-age CYSHCN	Share of transition-age CYSHCN who disenrolled	Share of all transition-age CYSHCN	Share of transition-age CYSHCN who disenrolled
All disability-related pathways	**83,904**	**82.4%**	**14,756**	**17.6%**	**6.0%**	**33.9%**	**11.6%**	**66.1%**
SSI related	65,062	85.1	9,681	14.9	5.1	34.2	9.8	65.8
Other SSI related	1,049	84.9	158	15.1	7.8	51.9	7.2	48.1
Other disability related	17,793	72.4	4,917	27.6	9.0	32.7	18.6	67.3

Notes: CYSHCN is children and youth with special health care needs. SSI is Supplemental Security Income. Transition-age CYSHCN are defined as children enrolled in disability pathways who are within 12 months of aging out of child Medicaid eligibility. Child Medicaid eligibility ends at age 19 in most states, with the exception of the District of Columbia, Florida, Maine, and Massachusetts, which have extended child Medicaid eligibility to age 21. The Transformed Medicaid Statistical Information System (T-MSIS) eligibility pathway codes included in each eligibility group are included in Table 5A-1.

Source: MACPAC analysis of T-MSIS, 2017–2019.

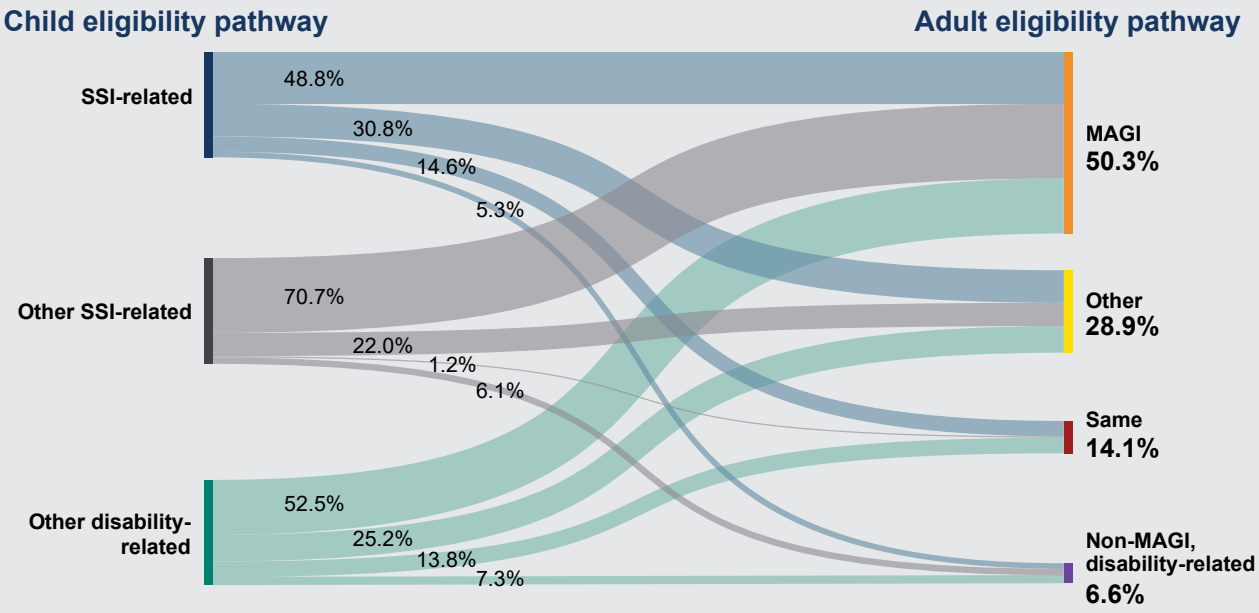
FIGURE 5A-1. Transition-Age Medicaid-Covered Children and Youth with Special Health Care Needs Who Remained Continuously Enrolled in Medicaid as Adults by Child and Adult Eligibility Pathways, 2017–2019



Notes: SSI is Supplemental Security Income. MAGI is modified adjusted gross income. Transition-age children and youth with special health care needs (CYSHCN) are defined as children enrolled in disability pathways who are within 12 months of aging out of child Medicaid eligibility. Child Medicaid eligibility ends at age 19 in most states, with the exception of the District of Columbia, Florida, Maine, and Massachusetts, which have extended child Medicaid eligibility to age 21. The child eligibility pathways show percentages of CYSHCN who transitioned to an adult eligibility group. The adult eligibility pathway percentages represent the percentage of all transition-age children who transitioned to each adult eligibility pathway group (e.g., of all transition-age CYSHCN, 77.9 percent maintain coverage in the same eligibility pathway). The Transformed Medicaid Statistical Information System (T-MSIS) eligibility pathway codes included in each eligibility group are included in Table 5A-1.

Source: MACPAC analysis of T-MSIS, 2017–2019.

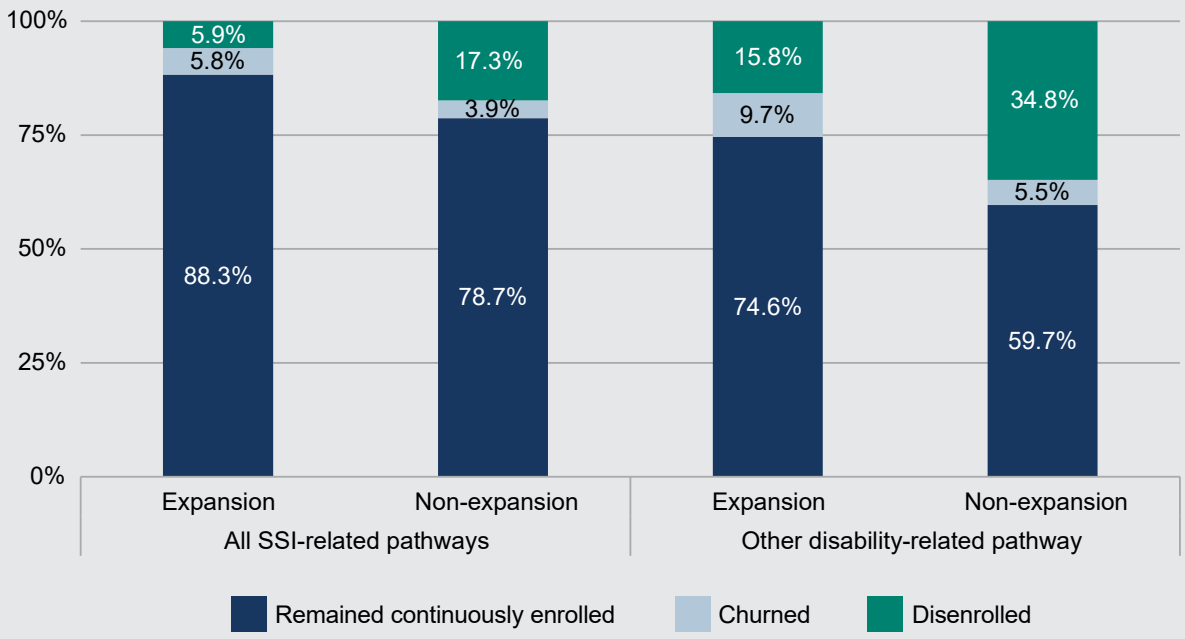
FIGURE 5A-2. Transition-Age Children and Youth with Special Health Care Needs Who Churned by Child and Adult Eligibility, 2017–2019



Notes: SSI is Supplemental Security Income. MAGI is modified adjusted gross income. The child eligibility pathways show percentages of children who transitioned to each adult eligibility pathway group. The adult eligibility pathway percentages represent the percentage of all transition-age children who transitioned to each adult eligibility pathway group (e.g., of all transition-age children, 14.1 percent maintain coverage in the same eligibility pathway). Transition-age children and youth with special health care needs are defined as children enrolled in disability pathways who are within 12 months of aging out of child Medicaid eligibility. Child Medicaid eligibility ends at age 19 in most states, with the exception of the District of Columbia, Florida, Maine, and Massachusetts, which have extended child Medicaid eligibility to age 21. A crosswalk of eligibility groups to the eligibility pathway codes in Transformed Medicaid Statistical Information System (T-MSIS) are included in Table 5A-1.

Source: MACPAC analysis of T-MSIS, 2017–2019.

FIGURE 5A-3. Coverage Outcomes for Transition-Age Children and Youth with Special Health Care Needs by Eligibility Pathway and State Adoption of Medicaid Expansion, 2017–2019

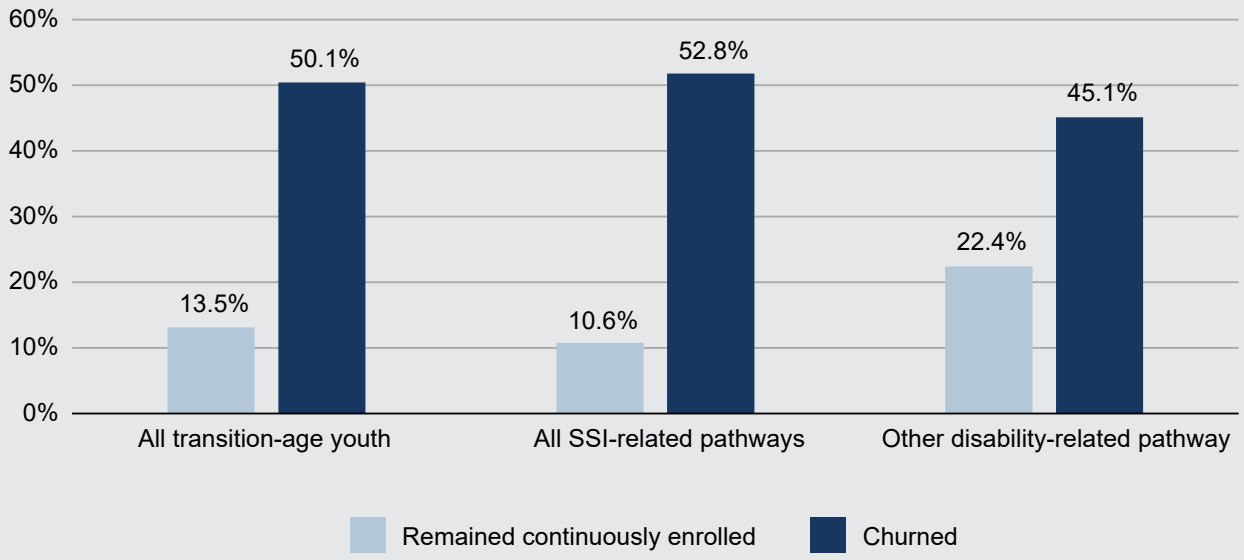


Notes: SSI is Supplemental Security Income. Transition-age children and youth with special health care needs are defined as children enrolled in disability pathways who are within 12 months of aging out of child Medicaid eligibility. Child Medicaid eligibility ends at age 19 in most states, with the exception of the District of Columbia, Florida, Maine, and Massachusetts, which have extended child Medicaid eligibility to age 21. A crosswalk of eligibility groups to the eligibility pathway codes in Transformed Medicaid Statistical Information System (T-MSIS) are included in Table 5A-1.

Expansion refers to the 35 states and the District of Columbia that, as of January 1, 2019, adopted Medicaid expansion and extended Medicaid eligibility to all adults younger than age 65 (including parents and adults without dependent children) with incomes below 133 percent of the federal poverty level. Non-expansion refers to states that have not adopted Medicaid expansion as of January 1, 2019 (KFF 2025).

Source: MACPAC analysis of T-MSIS, 2017–2019.

FIGURE 5A-4. Transition-Age Children and Youth with Special Health Care Needs by Eligibility Pathway Who Transition to an Expansion Eligibility Pathway as an Adult, 2017–2019



Notes: SSI is Supplemental Security Income. Transition-age children and youth with special health care needs are defined as children enrolled in disability pathways who are within 12 months of aging out of child Medicaid eligibility. Child Medicaid eligibility ends at age 19 in most states, with the exception of the District of Columbia, Florida, Maine, and Massachusetts, which have extended child Medicaid eligibility to age 21. A crosswalk of eligibility groups to the eligibility pathway codes in Transformed Medicaid Statistical Information System (T-MSIS) are included in Table 5A-1.

Source: MACPAC analysis of T-MSIS, 2017–2019.

Endnotes

[1] During the COVID-19 public health emergency, the Families First Coronavirus Response Act (P.L. 116-127) provided states with a temporary 6.2 percentage point increase in the federal medical assistance percentage (FMAP) if they met certain conditions, including a continuous coverage requirement for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020. The Consolidated Appropriations Act of 2023 (CAA, P.L. 117-328) decoupled the end of the continuous coverage requirement from the public health emergency. The CAA established an end date of March 31, 2023, for the requirement and a phase-down of the enhanced matching rate over the remainder of 2023 for states that met certain renewal processing and data reporting requirements.

[2] Acumen defined the last-best month as the most recent month containing a valid non-CHIP eligibility group code or a valid basis of eligibility (if eligibility group is missing or invalid). If the beneficiary has at least one validly enrolled month (i.e., at least one last-best month), they considered them validly enrolled for the given year. When using the final action eligibility file to define valid enrollment, Acumen further subset the enrollment records to the time when the date of birth and the date of death indicate the beneficiaries are still alive.

[3] The cohort of transition-age children and youth with special health care needs was defined as individuals between age 18 and 19 as of December 2017. Individuals who remained continuously enrolled in the year leading up to their 19th birthday and for the 12 months following their 19th birthday are considered continuously enrolled. Individuals who disenrolled for any period of time in 2018 (which includes individuals who were within 12 months of their 19th birthday) is defined as the disenrolled group. Those who disenrolled and reenrolled within 12 months of the month of disenrollment are defined as the “churn group.”

References

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. n.d. Implementation guide: Medicaid state plan eligibility: Eligibility groups—optional state supplement beneficiaries. Baltimore, MD: CMS. https://www.medicaid.gov/resources-for-states/downloads/macpro-ig-optional-state-supplement-beneficiaries.pdf.

KFF. 2025. Status of state Medicaid expansion decisions. May 9, 2025. Washington, DC: KFF. https://www.kff.org/status-of-state-medicaid-expansion-decisions/.

Mann, D., C. Irvin, A. Barrett, and S. Rouhani. 2022. *Rates of Medicaid churn and continuous coverage among children and working-age adults with disability-related eligibility.* Washington, DC: Mathematica. https://www.mathematica.org/publications/rates-of-medicaid-churn-and-continuous-coverage-among-children-and-working-age-adults.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2026. *CYSHCN transitions to adult Medicaid coverage*. Washington, DC: MACPAC. https://www.macpac.gov/publication/transitions-to-adult-medicaid-coverage-for-children-and-youth-with-special-health-care-needs/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021. *An updated look at rates of churn and continuous coverage in Medicaid and CHIP*. February 28, 2013. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf.

APPENDIX 5B: American Community Survey Methods and Findings

MACPAC worked with the State Health Access Data Assistance Center to examine survey data from the 2023 American Community Survey (ACS). We used these survey data to better understand the demographic characteristics and insurance coverage of youth and young adults with disabilities, defined based on self-reported disability and reported receipt of Supplemental Security Income (SSI) payments. We stratified and compared these results by those with and without self-reported disabilities, age groups (17–18 years old, 19 years old, and 20–25 years old), insurance type (Medicaid, private, and no insurance), and those who receive and do not receive SSI. We defined someone as having a self-reported disability if they reported having one or more of these six functional limitations: deaf or difficulty hearing, blind or difficulty seeing, difficulty concentrating and making decisions, difficulty with walking or climbing stairs, difficulty dressing or bathing, and difficulty with doing errands alone.

Findings

In this section we include the table from the analysis of the 2023 ACS referenced in the chapter.

TABLE 5B-1. Selected Demographic and Socioeconomic Characteristics of Youth and Young Adults with Self-Reported Disability by Age Group, 2023

Selected characteristics	17–18 years	19 years	20–25 years
Race and ethnicity			
Hispanic	24.1%	23.2%	21.5%*
White, non-Hispanic	49.7	51.4	54.9*
Black, non-Hispanic	13.9	12.0*	12.7*
American Indian and Alaska Native, non-Hispanic	0.8	0.5	0.7
Asian, non-Hispanic	2.9	3.2	3.1
Native Hawaiian and other Pacific Islander, non-Hispanic	–	–	0.2*
Other single and multiple races, non-Hispanic	8.6	9.4	6.9*
Insurance coverage			
Any Medicaid	48.2	39.5*	35.9*
Private only	44.3	50.1*	49.5*
Other (military or VA)	1.7	1.7	2.5*
Uninsured	5.8	8.7*	12.0*
Benefits programs			
Receives income from SSI	11.3	11.2	11.8
Self-reported disability			
Reports having 2 or more functional limitations	38.8	38.4	37.9
Reports having 3 or more functional limitations	13.4	14.0	12.5

Notes: SSI is Supplemental Security Income. VA is Veterans Affairs insurance. Disability status is defined using the self-reported disability status. Has a disability means the respondent reported yes for at least one of six functional limitations.

* Difference from Medicaid is statistically significant at the 0.05 level.

− Estimate not reported because it is too small of a sample size or it is unreliable because it has a relative standard error greater than or equal to 30 percent.

Source: MACPAC analysis of the American Community Survey, 2023.

Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on May 7, 2026.

Children and Youth with Special Health Care Needs Transitions to Adult Coverage

5.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to amend 42 CFR 435.919(b)(6) to require states to send a notice a minimum of 60 days in advance of children and youth with special health care needs (CYSHCN) aging out of child Medicaid eligibility to inform them that the renewal process has been initiated. CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

5.1 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
No	0	

5.2 State Medicaid agencies should provide children and youth with special health care needs (CYSHCN) who are aging out of child Medicaid eligibility with a minimum of 30 days to respond to requests for information to complete Medicaid redeterminations in accordance with 42 CFR 435.919(c)(1). CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

5.2 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
No	0	

5.3 To ensure the accuracy of information provided by the Social Security Administration (SSA) to Medicaid beneficiaries enrolled in Supplemental Security Income (SSI)-related eligibility pathways who are being notified that they are losing eligibility for SSI, the Secretary of the U.S. Department of Health and Human Services, through the Centers for Medicare & Medicaid Services, should coordinate with SSA to review and update model notice language pertaining to Medicaid in SSA's Program Operations Manual System manual paragraphs. The model language should clearly indicate that the individual may retain their Medicaid coverage while the state Medicaid agency takes steps to redetermine the individual on a new basis of eligibility. Additionally, the model language should describe, in general terms, the steps the individual needs to follow to complete the Medicaid redetermination that are specific to 1634, SSI criteria, and 209(b) states.

5.3 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
No	0	

5.4 State Medicaid agencies should implement optional Medicaid eligibility for children and youth with special health care needs (CYSHCN) up to age 21 who are not otherwise eligible for and enrolled in mandatory coverage or optional full Medicaid coverage under the state plan (42 CFR 435.222 and 42 CFR 435.223). CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

5.4 voting result	#	Commissioner
Yes	16	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McFadden, Nardone, Snyder
No	1	McCarthy

5.5 To ensure children and youth with special health care needs (CYSHCN) receive a full 12-month continuous eligibility period in their final year of child Medicaid eligibility, Congress should amend § 1902(e)(12) of the Social Security Act to require states to provide CYSHCN with a 12-month continuous eligibility period that lasts a full 12 months from the date of the eligibility determination, even if during the continuous eligibility period, an individual reaches the upper age limit for the eligibility pathway by which they are eligible for Medicaid. This 12-month continuous eligibility period should apply to all CYSHCN who receive coverage from a mandatory or optional child eligibility pathway, including optional pathways covering youth above age 18. CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

5.5 voting result	#	Commissioner
Yes	14	Allen, Bjork, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Killingsworth, McFadden, Nardone, Snyder
No	3	Brown, Karl, McCarthy

5.6 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to issue guidance to states on existing authorities for supporting children and youth with special health care needs (CYSHCN) with Medicaid redeterminations and transitioning to adult Medicaid coverage. The guidance should address authorities to cover case management, transition planning for child-only Section 1915(c) home- and community-based services waivers, and the state optional pathway to cover children up to age 21. CYSHCN include, but are not limited to, children who are enrolled in Medicaid through Supplemental Security Income (SSI)-related eligibility pathways who are not eligible for SSI as adults and are transitioning to non-SSI related pathways when they reach age 19, the Katie Beckett pathway for children with disabilities, those eligible for Medicaid under the Tax Equity and Fiscal Responsibility Act, and children who qualify to receive an institutional level of care.

5.6 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
No	0	

Chapter 6:

Exploring the Role of the State Medicaid Agency in the Program of All-Inclusive Care for the Elderly

Exploring the Role of the State Medicaid Agency in the Program of All-Inclusive Care for the Elderly

Recommendations

6.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to update audit protocols and three-way program agreements to facilitate joint audits of Program of All-Inclusive Care for the Elderly organizations with state administering agencies. Audit coordination should include joint planning of audit scopes, sharing documentation requests, and reviewing evidence concurrently, while preserving CMS's responsibility for assessing federal requirements and states' responsibility for assessing state-specific requirements.

6.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to aggregate and publicly release, in a user-friendly format on the CMS website, existing Program of All-Inclusive Care for the Elderly (PACE) performance data, including data PACE organizations submit through CMS's Health Plan Management System as well as enrollee satisfaction data collected as part of PACE organization quality improvement programs pursuant to 42 CFR 460.134(a)(2).

6.3 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to amend regulations at 42 CFR 460 Subpart H to develop a standardized, national quality measure set for Program of All-Inclusive Care for the Elderly (PACE) organizations. Quality data should be compiled and made publicly available in an accessible format. CMS should follow three key principles when developing a PACE quality measure set: engage stakeholders collaboratively; minimize reporting burden by focusing on the most meaningful measures; and prioritize standardized measures that enable comparability across programs where feasible.

Exploring the Role of the State Medicaid Agency in the Program of All-Inclusive Care for the Elderly

Key Points

- The Program of All-Inclusive Care for the Elderly (PACE) is a provider-led, home- and community-based care model serving adults age 55 and older who are eligible for nursing home care but can live safely in the community at the time of enrollment.
- Findings from our review of federal and state PACE oversight documents and stakeholder interviews identified variation in how states oversee PACE organizations, including differences in oversight tools, monitoring practices, data collection, and coordination with the Centers for Medicare & Medicaid Services (CMS).
- PACE programs operate under a required, standardized three-way program agreement among the PACE organization, CMS, and the state. Some states also use optional two-way program agreements between the state and PACE organizations to supplement the federal oversight framework by clarifying expectations, adding specificity, and supporting enforcement of requirements that may not be explicitly detailed in federal regulations.
- Oversight of PACE organizations is a shared responsibility between CMS and states, requiring coordination across multiple activities, including monitoring, audits, and data use. Stakeholders described this relationship as collaborative and also identified opportunities to improve coordination between federal and state oversight efforts, particularly in audit processes.
- Stakeholders highlighted challenges related to limited transparency and inconsistent availability of PACE performance and quality data. Limited and non-standardized data as well as the relatively small and heterogeneous PACE population make it difficult to compare performance and outcomes across PACE organizations and states.
- These findings point to three key policy needs: (1) improved coordination of oversight activities, (2) greater transparency of program performance data, and (3) a standardized approach to data collection and quality measurement.

CHAPTER 6: Exploring the Role of the State Medicaid Agency in the Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is a provider-led, home- and community-based care model serving adults age 55 and older who are eligible for nursing home care but can live safely in the community at the time of enrollment.[1] Approximately 75 percent of participants are dually eligible for Medicare and Medicaid (CMS 2024a). PACE delivers fully integrated medical and non-medical services primarily through adult day care centers, with additional services provided in the home and post-acute care settings, and is designed as a community-based alternative to institutional care aimed at delaying or preventing nursing facility and hospital use (CMS 2011).

Understanding how PACE operates and is overseen has been a key focus of the Commission's recent analytic work. During the 2024–2025 cycle, staff conducted a policy scan and stakeholder interviews to examine the program's statutory and regulatory framework and highlighted findings on eligibility, enrollment, service delivery, oversight, and payment in the Commission's June 2025 report to Congress (MACPAC 2025). The prior chapter discussed research on PACE participant outcomes, including studies examining hospitalization, nursing facility use, mortality, and behavioral health outcomes (MACPAC 2025).[2] Although PACE is widely recognized as a highly integrated care model for dually eligible individuals, Commissioners and stakeholders raised concerns about transparency and ambiguity in state-level oversight, particularly regarding the role of state Medicaid agencies.

In response, the Commission sought to better understand state oversight of PACE and its interaction with federal oversight activities. Our analysis focused on states' legal authority and capacity to establish, monitor, and enforce standards in PACE programs, including their statutory and regulatory responsibilities (as distinct from federal oversight), the tools states use to oversee PACE organization performance and compliance, operational resources and capacity constraints that affect oversight, and the extent to which states measure and evaluate the quality of Medicaid services provided to PACE participants.

To inform this work, staff conducted a review of key federal and state oversight documents, including required three-way program agreements among the Centers for Medicare & Medicaid Services (CMS), states, and PACE organizations; optional two-way agreements between states and PACE organizations; and waiver requests submitted under Section 903 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554), known as "BIPA 903 waivers." Staff also conducted stakeholder interviews with state Medicaid officials, CMS officials, and PACE experts.

Findings from this work identified key challenges and barriers to transparency in PACE program performance. State and federal officials reported variation in oversight practices, including differences in state and CMS roles, the use of two-way program agreements, and oversight tools. They also noted limited and non-standardized data and inconsistent approaches to measuring performance and outcomes. Some states reported capacity constraints, particularly staffing and resource limitations in growing programs. In addition, stakeholders highlighted coordination gaps, including misalignment and duplication in oversight activities. These challenges point to three key policy needs: (1) improved coordination of oversight activities, (2) greater transparency of program performance data, and (3) a standardized approach to data collection and quality measurement.

Based on these findings, the Commission makes three recommendations to improve coordination between state and federal oversight activities and to enhance the availability of accessible information on PACE performance and quality. The Commission's recommendations are:

6.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to update audit protocols and three-way program

agreements to facilitate joint audits of Program of All-Inclusive Care for the Elderly organizations with state administering agencies. Audit coordination should include joint planning of audit scopes, sharing documentation requests, and reviewing evidence concurrently, while preserving CMS's responsibility for assessing federal requirements and states' responsibility for assessing state-specific requirements.

6.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to aggregate and publicly release, in a user-friendly format on the CMS website, existing Program of All-Inclusive Care for the Elderly (PACE) performance data, including data PACE organizations submit through CMS's Health Plan Management System as well as enrollee satisfaction data collected as part of PACE organization quality improvement programs pursuant to 42 CFR 460.134(a)(2).

6.3 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to amend regulations at 42 CFR 460 Subpart H to develop a standardized, national quality measure set for Program of All-Inclusive Care for the Elderly (PACE) organizations. Quality data should be compiled and made publicly available in an accessible format. CMS should follow three key principles when developing a PACE quality measure set: engage stakeholders collaboratively; minimize reporting burden by focusing on the most meaningful measures; and prioritize standardized measures that enable comparability across programs where feasible.

To provide context for these recommendations, the chapter begins with our analytic approach in this work and background on the PACE model, including oversight documents used by CMS and states. It then describes our findings on state oversight of PACE organizations, coordination between state and federal oversight efforts, and the collection of quality and performance data. The chapter then presents the Commission's three recommendations with supporting rationale and implications for federal spending, state Medicaid agencies, PACE organizations, and enrollees.

Analytic Approach

We contracted with the Center for Health Care Strategies to review the primary federal and state documents used to govern and operate the PACE model and to conduct stakeholder interviews with states and other PACE subject matter experts. The document review focused on three key document types: required three-way program agreements among CMS, states, and PACE organizations; optional two-way program agreements between state administering agencies (SAAs) and PACE organizations; and BIPA 903 waiver requests submitted by PACE organizations to states and CMS. We partnered with the Center for Health Care Strategies to compare a publicly available three-way program agreement template with two-way program agreements from 16 states and the District of Columbia and review BIPA 903 waiver requests from PACE organizations in 9 states to assess how these flexibilities might affect state oversight responsibilities. In total, we reviewed 65 distinct documents between August and December 2025. Because there is no centralized database of two-way program agreements or BIPA 903 waivers, these documents were collected directly from states and CMS.

We also spoke with key state officials and one state PACE association in six states: California, Colorado, Kentucky, New Jersey, North Carolina, and Ohio. These states were selected to capture variation in geography, political context, integrated care offerings, PACE program maturity, and oversight approach—specifically, the presence or absence of two-way program agreements. We also interviewed federal stakeholders from CMS, including the Center for Medicaid and CHIP Services, the Center for Medicare, and the Office of Program Operations & Local Engagement as well as the National PACE Association (NPA) and an independent national PACE expert.

Background

PACE is designed as a community-based alternative to institutional care, aimed at delaying or preventing nursing facility and hospital use (CMS 2011). To achieve this, PACE organizations rely on an interdisciplinary team of providers who assess participants' needs; develop care plans; and provide continuous, coordinated care in the community. As a fully integrated model combining Medicare and Medicaid financing and service delivery, PACE relies on a shared federal-state oversight structure involving CMS and states.

PACE's design and oversight structure create unique challenges for federal and state regulators (MACPAC 2025). For example, statutory and regulatory guidance do not always clearly delineate how oversight responsibilities are divided between CMS and state Medicaid agencies. In the first phase of this work, stakeholders—including federal and state officials and PACE organizations—described the oversight structure as complex and, at times, lacking clear ownership, noting that responsibilities are distributed across multiple units within CMS and between federal and state entities.[3] Stakeholders also highlighted that PACE does not fit neatly within existing oversight frameworks, relying in part on Medicare Advantage infrastructure while operating as a distinct provider-led model. Interviewees further reported that limited and non-standardized data, combined with a small and heterogeneous PACE population, make it difficult to assess performance and compare outcomes across programs (MACPAC 2025). Together, these factors complicate coordination of oversight activities and limit transparency into PACE program performance. These challenges are reflected in the findings presented in this chapter, including variation in oversight practices, gaps in coordination, and limitations in available data.

During 2024, more than 14 million people were dually enrolled in Medicare and Medicaid (CMS 2025a). Of these, 73 percent were eligible for full Medicaid benefits, referred to as "full-benefit dually eligible beneficiaries," and the remaining 27 percent were eligible only for Medicaid assistance with certain Medicare premiums, cost sharing, or both, referred to as "partial-benefit dually eligible beneficiaries." As of December 2024, just over 735,000 full-benefit dually eligible beneficiaries received care through one of the three models that provide fully integrated care: Medicare Advantage fully integrated dual eligible special needs plans, Medicare-Medicaid Plans, and PACE (ICRC 2025).[4]

As of May 2026, nearly 78,000 dually eligible individuals were enrolled in 202 PACE programs across 33 states and the District of Columbia (CMS 2026, NPA 2026). Because monthly enrollment data from CMS exclude Medicaid-only beneficiaries, total PACE enrollment is closer to 92,000 individuals (NPA 2026).[5] CMS has reported that approximately 75 percent of PACE enrollees are dually eligible for Medicare and Medicaid, while the remaining 25 percent are primarily Medicaid-only beneficiaries, although this estimate is based on a different data source than the monthly enrollment counts (CMS 2024a).[6]

PACE began in San Francisco, California, in 1971 as a community-based model to provide comprehensive care to older adults and was later authorized as a permanent Medicare program and a Medicaid state plan option (§ 1894 and § 1934 of the Social Security Act (the Act)) through the Balanced Budget Act of 1997 (P.L. 105-33) (CMS 2011). The statute established the nation's first permanent integrated care model (MACPAC 2020). It also specified five core principles of the PACE model that the Secretary of the U.S. Department of Health and Human Services (HHS) may not modify or waive:

- the focus on frail, elderly qualifying individuals who require the level of care provided in a nursing facility;
- the delivery of comprehensive, integrated acute and long-term care services;
- the interdisciplinary team approach to care management and service delivery;
- capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals; and
- the assumption by the provider of full financial risk.

PACE organizations must offer a comprehensive range of services, including all Medicare- and Medicaid-covered services as well as other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status, without typical benefit limitations and on a continuous basis across settings (42 CFR 460.90, 460.98). An interdisciplinary team coordinates care and assesses participants, develops care plans, and manages services delivered in PACE centers, participants' homes, and institutional settings when needed. An estimated 95 percent of PACE participants live at home (NPA 2019). This flexibility allows PACE organizations to deliver a tailored mix of medical and non-medical services across the full continuum of care, supporting participants' ability to remain in the community for as long as possible.

Oversight of PACE organizations reflects the model's unique dual-authority structure under Section 1894 (Medicare) and Section 1934 (Medicaid) of the Act, which establish PACE as a permanent program jointly administered by the federal government and participating states. This statutory framework assigns shared responsibility to CMS (through the HHS Secretary) and states to approve, monitor, and oversee PACE organizations. Within this framework, CMS establishes implementing regulations and requires PACE organizations to collect, maintain, and report data needed to monitor program operations, outcomes, compliance, and financial performance. States administer the Medicaid component of the benefit and oversee state-specific program implementation and operations. Federal regulations further operationalize these requirements by establishing detailed standards for program administration, service delivery, quality assurance, and oversight (42 CFR 460). CMS may also incorporate updates to PACE regulations in its annual rulemaking on Medicare Advantage and Medicare Part D prescription drug coverage (CMS 2024b).

PACE Oversight Framework

Both Section 1894 and Section 1934 of the Act require CMS and states to share responsibility for key monitoring and enforcement functions. CMS and states collaborate to oversee PACE organizations, including jointly reviewing program operations, determining eligibility, and assessing compliance with regulatory requirements. They also monitor performance and quality, including by reviewing program data submitted by providers and, in some cases, developing outcome measures. CMS retains ultimate authority over federal PACE regulations and enforcement of federal program requirements, including issuing regulations; approving, denying, or deeming approved provider applications; and taking enforcement actions such as requiring corrective action plans (CAPs), withholding payments, or terminating agreements.[7] States may also independently oversee compliance with state requirements, conduct audits, implement corrective actions, and terminate program agreements in accordance with state authority and contract provisions. Together, this structure establishes PACE as a collaborative federal-state model in which states serve as active coadministrators and CMS provides overarching regulatory direction and primary authority over federal program requirements.

This federal-state oversight framework is operationalized through required three-way program agreements that define the roles and responsibilities of CMS, SAAs, and PACE organizations. States may also use additional tools to operationalize and supplement this framework, including optional two-way program agreements that establish state-specific requirements and processes. In addition, Section 903 of BIPA authorizes CMS to grant waivers of certain regulatory requirements, providing another mechanism that can shape how oversight is implemented in practice.

Required three-way program agreements

PACE organizations operate under a three-way program agreement among the PACE organization, CMS, and the SAA (CMS 2000). The agreement is divided into seven articles with standardized language. Many of the articles have related appendices that contain state- and organization-specific information (e.g., service area or disenrollment policies). Table 6-1 provides additional details on the structure of the three-way program agreement.

Although the core sections of the agreement are standardized, CMS allows states to include two types of optional content. First, the agreement may include additional PACE organization–specific requirements for determining PACE eligibility (42 CFR 460.150(b)(4)). Second, the agreement may include additional terms and conditions agreed upon by all three parties, provided they are consistent with Section 1894 and Section 1934 of the Act and regulations (42 CFR 460.32(b)(2)).

TABLE 6-1. Program of All-Inclusive Care for the Elderly Three-Way Program Agreement Structure

Section	Description	Related appendix
Article I. Term of Agreement	Time frame for contract year	–
Article II. A. Governing Body	Contact information for PACE organization management	Appendix A
Article II. B. PACE Structure	Description of the organizational structure of the PACE organization	Appendix B
Article II. C. Service Area and PACE Sites	Description of designated service area of PACE organization	Appendix C
Article II. D. Participant Bill of Rights	PACE organization makes available to all enrollees a list and explanation of the rights to which they are entitled	Appendix D
Article II. E. Services	Required health care services that include, at a minimum, all services required by 42 CFR 460.92 and 460.94	–
Article II. F. Eligibility, Enrollment, and Disenrollment	General PACE eligibility criteria, PACE organization's eligibility and enrollment policies, state role in eligibility determinations, and voluntary and involuntary disenrollment processes	Appendices E, F, G, H
Article II. G. Grievances and Appeals	Rights of PACE enrollees to grieve medical and non-medical decisions and submit appeals	Appendices I, J
Article II. H. Quality Assessment and Performance Improvement	Description of PACE organization's quality assessment and performance improvement program, CMS and state standardized quality measures, and how the PACE organization will provide data and information on participant care activities	Appendices K, L
Article II. I. Data Collection and Reporting Requirements	The PACE organization collects data and submits reports as required by CMS and the state, and CMS and the state have the right to inspect, evaluate, and audit PACE organizations	–
Article III. Payment	Description of Medicare and Medicaid payment rates	Appendices M, N

TABLE 6-1. (continued)

Section	Description	Related appendix
Article IV. Termination of the Agreement	CMS or the state may terminate the agreement at any time for cause, the PACE organization may terminate agreement after timely notice, and the PACE organization must provide a detailed written plan for phasedown	Appendix O
Article V. Requirements of Laws and Regulation	PACE organization agrees to comply with all applicable federal, state, and local laws and regulations	–
Article VI. Changes to the Program Agreement	CMS has the authority to incorporate any additional terms agreed upon by all parties	–
Article VII. State Administering Agency Requirements	Description of the role and related activities of the state, including compliance monitoring, enrollment and disenrollment, marketing, and state licensure requirements	Appendices P, Q, R, S, T

Notes: PACE is Program of All-Inclusive Care for the Elderly. CMS is Centers for Medicare & Medicaid Services.

– Dash indicates no related appendix for the article.

Source: CMS 2000.

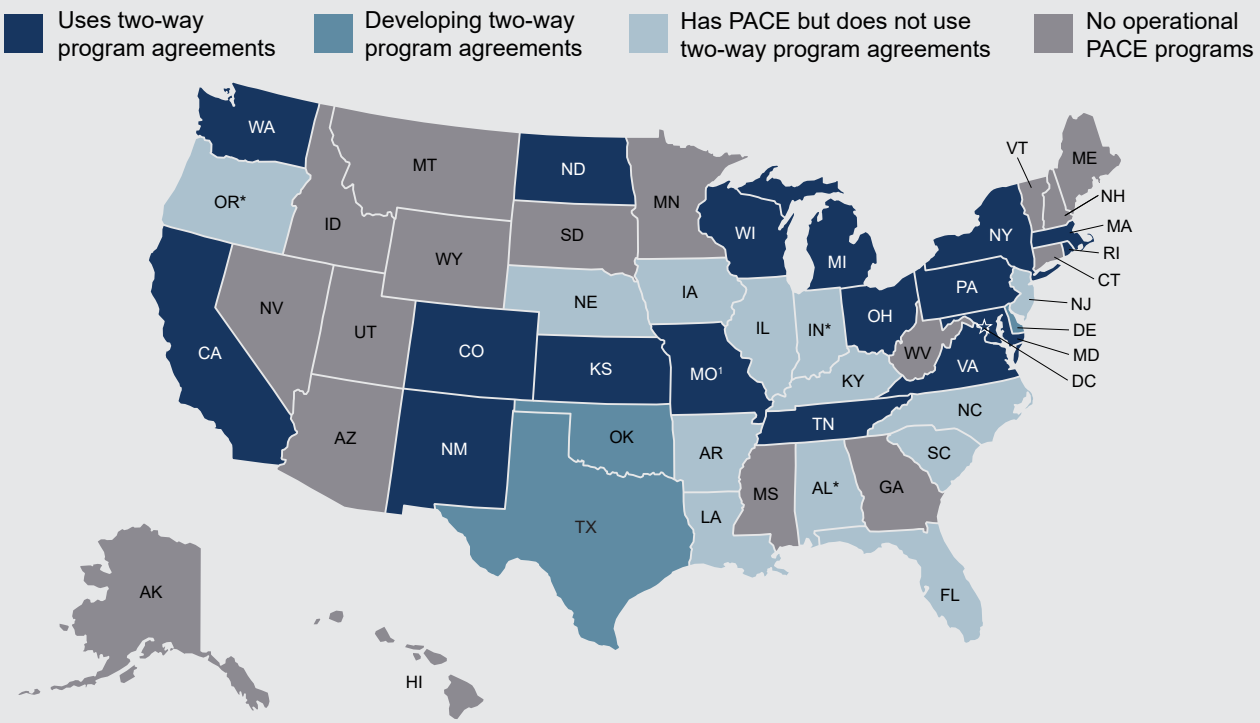
Article VII of the agreement defines key responsibilities of the SAA in implementing and overseeing PACE programs. These responsibilities include establishing enrollment and disenrollment processes, reviewing PACE marketing materials, setting optional licensure requirements for PACE organizations, and monitoring program compliance. The agreement specifies that states and CMS conduct certain oversight activities jointly, such as trial period monitoring, ongoing program monitoring, and oversight of CAPs. It also assigns states primary responsibility for other activities, such as conducting readiness reviews and monitoring level of care determinations and redeterminations, with limited or no direct CMS involvement in those areas.

State two-way program agreements

In addition to the required three-way program agreements, some states use optional two-way program agreements between SAAs and PACE organizations to supplement the federal oversight framework. Among the 33 states and the District of Columbia with active PACE programs, 16 states and the District of Columbia reported using two-way program agreements, and 3 additional states reported that they are developing them (Figure 6-1). Washington, which is included among the 16 states, uses a two-way program agreement alongside state statutory provisions. Missouri is not included in the count of states using two-way program agreements because it no longer maintains an active agreement; however, Missouri is included in this analysis because the state codified PACE requirements in statute based largely on a previous two-way program agreement. States that do not use two-way agreements generally rely on the three-way program agreement and federal regulations, while some have adopted alternative approaches, such as codifying requirements in state statute or developing program manuals.

State use of two-way program agreements. To understand how SAAs define and implement oversight responsibilities, we analyzed two-way program agreements submitted by 16 states and the District of Columbia. We found that states generally use these agreements to supplement the federal oversight framework by adding more detailed and state-specific requirements, resulting in substantial variation across states (Table 6-2, Table 6A-1).

FIGURE 6-1. Use of Program of All-Inclusive Care for the Elderly Two-Way Program Agreements by State, 2026



Notes: PACE is Program of All-Inclusive Care for the Elderly. MACPAC was unable to review Maryland's two-way program agreement due to state delays in Freedom of Information Act requests. However, the Maryland Code of Regulations Section 10.09.44.04 references a two-way program agreement.

[1] Missouri relies on state statute largely derived from a previous two-way program agreement.

* State did not respond to outreach.

Source: MACPAC, 2026, analysis of two-way program agreements and state statute submitted by states.

Across states, two-way program agreements most commonly address areas already identified in the three-way program agreement: (1) trial period monitoring; (2) ongoing monitoring; (3) CAPs; (4) enrollee level of care redeterminations; and (5) reporting on quality, financial performance, and encounter data. However, the scope and specificity of these provisions vary substantially. Some states include detailed requirements. For example, Ohio requires CAPs to identify root causes of deficiencies, specify corrective actions and methodologies, and assign responsible staff within defined time frames. Wisconsin authorizes intensive oversight activities, including the deployment of state staff or representatives on site to support compliance. Other states include more general provisions that largely mirror federal requirements. States also vary in how they define encounter data reporting requirements, ranging from narrower definitions tied to Medicaid-covered services for which the PACE organization is financially responsible (e.g., California) to broader frameworks that encompass a wider range of services and reporting circumstances (e.g., North Dakota). For a detailed review of two-way program agreements, see Appendix 6A.

Despite this variation, two-way program agreements generally do not substantively modify or expand the statutory role of the SAA. Instead, they function as a mechanism for operationalizing oversight within the existing federal-state framework by clarifying expectations, adding specificity, and supporting enforcement of requirements that may not be explicitly detailed in federal regulations.

Stakeholder interviews reinforced these findings. Among the six states interviewed, three reported using two-way program agreements and described them as useful tools for incorporating state-specific contractual details beyond the three-way program agreement. Officials noted that these agreements allow states to reference and enforce requirements that extend beyond federal regulations and strengthen oversight expectations.

TABLE 6-2. Use of Program of All-Inclusive Care for the Elderly Two-Way Program Agreements by Category and State

Category	States
Trial period monitoring	CA, ND, VA
Ongoing monitoring (after trial)	CA, CO, DC, KS, MA, MI, MO, ND, NM, NY, OH, PA, RI, TN, WA, WI
Corrective action plan requirements	CA, CO, MA, ND, OH, PA, TN, VA, WI
Level of care redeterminations (adds detail)	CA, ND, NY, OH, TN, WI
Reporting requirements	
Grievances and appeals	CA, MA, MI, NY, TN, VA, WI
Enrollments	CA, CO, MI, ND, TN, WI
Disenrollments	CA, CO, ND, TN, WI
Incidents	CA, CO, OH, TN
Enrollment denials	CO, ND
Media events	CO
Financial data	CA, CO, KS, MI, NM, NY, PA, VA, WI
Quality improvement plans	CA, MA, MI, ND, NY, OH, PA, TN
Encounter data	CA, CO, ND, NY, OH, TN, WI
Service utilization data	CA, KS, MA, NM, OH
Fraud and abuse	ND, NY, OH, VA, WI
Statistical data	CA, MA, ND, NM
Provider listings	CA, MI, MO, TN
Other/miscellaneous	CA, MA, MI, TN, ND
Additional SAA roles	
Marketing materials/plan review	CA, MA, OH, TN
Outreach/beneficiary education	CA, KS, WI
Clinical operations	MI
Technical assistance/administrative support	CA, WI

Notes: SAA is state administering agency. Missouri's provisions appear in state statute, reflecting a prior two-way program agreement.

Source: MACPAC, 2026, analysis of two-way program agreements submitted by states.

In these states, officials emphasized that two-way agreements support oversight by aligning expectations across programs and incorporating state-specific contractual provisions. In one state, officials described the agreement as the result of ongoing collaboration with PACE organizations, in which providers reviewed draft language and provided feedback, resulting in a shared understanding of oversight expectations. In another state, officials reported that they modeled the agreement on Medicaid managed care and dual eligible special needs plan (D-SNP) contracts, allowing the state to align oversight standards across programs while maintaining PACE-specific requirements. In a third state, officials highlighted that the agreement's requirement for PACE organizations to submit operational policies and procedures on an ongoing basis improves the state's ability to monitor compliance in real time. Across these states, officials emphasized that more detailed contractual structures strengthen their ability to articulate compliance expectations and support enforcement actions.

Among states that do not use two-way program agreements, officials generally viewed them as redundant with existing federal regulations and the three-way program agreement. One state reported that an additional agreement was unnecessary given the broad authority already provided under federal regulations and the three-way program agreement, while another previously used a two-way agreement but later concluded that the three-way agreement alone sufficiently defined roles and responsibilities. In a third state, perspectives differed across agencies: The department of aging (the state's SAA) viewed a two-way agreement as potentially useful, while the state Medicaid agency considered the existing three-way agreement sufficient; as an alternative, the Medicaid agency is developing a state PACE manual to document program requirements and policies.

Federal officials reported that they are generally not involved in the development or implementation of state two-way program agreements and do not routinely review them, although they may review agreements upon state request to ensure consistency with federal regulations. They noted that an increasing number of states are developing these agreements as the PACE program expands and described them as tools that allow states to incorporate state-specific requirements or licensing provisions, provided they do not conflict with federal rules.

BIPA 903 waiver requests

Section 903 of BIPA authorizes CMS to approve waivers of certain Medicare and Medicaid regulatory requirements for PACE organizations. Under this process, PACE organizations submit waiver requests to the SAA, which reviews the request before forwarding approved requests to CMS for final determination. Although CMS retains final approval authority, certain core elements of the PACE model may not be waived under Section 1894 and Section 1934 of the Act, including requirements related to the population served, comprehensive service delivery, the interdisciplinary care model, and the program's financing structure and assumption of full financial risk (CMS 2024c).

To better understand the use of BIPA 903 waiver authority, we reviewed waiver requests submitted by PACE organizations to states, including both approved and denied requests from nine states with active PACE programs. However, many of the waiver requests staff reviewed did not contain information about whether they were approved or denied.

Analysis of nearly 50 waiver requests indicates that organizations primarily use this authority to seek operational flexibility. Nearly all waiver requests clustered around two areas: flexibility in conducting enrollee assessments and service determinations and modifications to interdisciplinary team staffing requirements. Requests related to enrollee assessments most commonly sought to continue the use of remote or telehealth-based assessments following temporary flexibilities granted during the COVID-19 public health emergency. Requests related to staffing typically sought permission to substitute other qualified professionals for master's level social workers in response to workforce shortages. For a detailed analysis of the BIPA 903 waiver requests reviewed, see Appendix 6B.

Federal officials described the waiver process as discretionary and case specific, with CMS generally less likely to approve requests for remote assessments after the end of the public health

emergency while more frequently granting temporary flexibility for workforce-related requests. Although CMS retains final approval authority, federal officials noted that waiver requests are rarely approved without state support in practice, effectively making state approval a prerequisite and positioning the process as a jointly conditioned federal-state oversight mechanism. Despite this practice, state interviewees reported limited engagement with BIPA 903 waivers and generally did not view them as a central component of their oversight activities.

State Oversight of PACE Organizations

States play a central role in overseeing PACE organizations, and their approaches vary across multiple areas, including oversight tools, quality measurement, data use, and available resources. Although all states operate within a common federal framework, differences in how they implement oversight result in variation in monitoring practices and the extent to which states assess performance and outcomes. The following sections describe these differences and the factors that shape states' oversight activities.

States use a range of tools to oversee PACE organizations with variation in enforcement and application

State officials reported using a variety of tools to support oversight and monitoring of PACE organizations, many of which were developed specifically for their state PACE program. For example, one state developed a state-specific audit tool used annually to collect data from PACE organizations, while another used policy letters to communicate state requirements. This state also relies on clinical coverage policies developed for each Medicaid provider type, and all interviewed states use state regulations and licensing requirements to support oversight efforts.

All states we interviewed have PACE-specific regulations in their administrative code. Most officials did not describe in detail how they apply these regulations to oversight activities. However, one official noted that state regulations allow flexibility to interpret and implement federal requirements in line with state priorities, rather than relying solely on CMS's interpretation. Federal officials and a PACE provider association reported that not all states regularly update their PACE regulations, and some older state regulations or licensing requirements have conflicted with recent federal updates.

Five states reported including enforcement tools, such as enrollment restrictions or financial penalties, in their oversight approach, though these tools are used infrequently. One state reported using enrollment sanctions only once since 2019, while another recently added sanction authority through state regulations. A PACE provider association observed that federal enforcement actions typically occur during a PACE organization's initial three-year trial period and speculated that CMS's focus on trial period audits, rather than routine audits, may contribute to higher enforcement rates during that period.

States vary widely in how they measure and assess PACE performance

States use a range of approaches to assess PACE organization performance, including participant experience measures, state-specific reporting requirements, and, in some cases, more structured quality measurement strategies. States also vary in the types of data they require PACE organizations to report beyond federal requirements, reflecting differences in how states define and monitor program performance. For example, some states require additional reporting on service utilization, fraud and abuse, and enrollee characteristics, while others emphasize outcome measures or operational data such as provider listings or day center attendance (Appendix 6A). Although all PACE organizations report certain quality data to CMS in accordance with federal requirements (e.g., enrollment, appeals and grievances, immunizations, falls, and critical incidents), states differ in how they supplement these data and the extent to which they use available information to monitor performance and outcomes.

State approaches to quality measurement. PACE organizations report a variety of quality data to CMS in accordance with federal regulatory requirements (CMS 2024d). However, this reporting is specific to PACE organizations and not based on standardized quality measures that both Medicare and Medicaid managed care organizations commonly submit to CMS, such as the Healthcare Effectiveness Data and Information Set (HEDIS), the Medicare Advantage and Prescription Drug Plan Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, or the CAHPS Home- and Community-Based Services (HCBS) survey. Although some of the information that PACE organizations report to CMS overlaps with information reported in managed care programs—such as immunizations, emergency department (ED) visits, and grievances and appeals—PACE organizations do not report this information to CMS in the same format as managed care plans, making it difficult to compare programs (CMS 2023).

Four of the states we interviewed require PACE organizations to report participant satisfaction. One of these states uses its two-way program agreement to specifically require PACE organizations to report satisfaction survey results from the Integrated Satisfaction Measurement for PACE (I-SAT) tool, which our interviews revealed is the most common tool that PACE organizations use to comply with federal requirements to conduct satisfaction surveys. A PACE provider association noted that 95 percent of PACE organizations use the I-SAT to collect data on participant satisfaction. Two of these states request results from PACE organization satisfaction surveys annually, though they do not specify which survey PACE organizations must use. Another state administers the National Core Indicators—Aging and Disabilities (NCI-AD) survey to PACE participants at all its PACE centers, though NCI-AD is not designed specifically for the PACE population. Previous interviews with state and federal officials revealed that participant satisfaction survey results are not routinely shared with CMS, although CMS may review quality-improvement measures during audits or discuss survey results with PACE organizations as part of quality improvement plans.

One state we interviewed has a more comprehensive quality strategy for its PACE organizations. The state developed a value-based payment (VBP) program to provide incentives for performance improvement and requires PACE organizations to report on 15 quality measures, 8 of which are tied to the VBP program. The state requires PACE organizations to use a quality reporting template included in the state's two-way program agreement. The measures used in the VBP program include both process and outcome measures, such as PACE participant satisfaction survey response rates, participant engagement after inpatient discharge, medication reconciliation, percentage of participants not in nursing homes, percentage of voluntary disenrollment, fall rates, and hospital admission rates. Another state uses a portal for PACE organizations to submit quality data on a quarterly basis, including data on flu and pneumococcal vaccinations, ED visits, hospital admissions and readmissions, falls, and demographics. Although the state noted that some of these metrics overlap with data PACE organizations submit to CMS, the state said it is tracking them in greater detail. For example, state data collection on ED visits and hospital admissions includes documentation of reasons for admission so the state can determine whether a readmission is occurring for the same reason as the original admission.

PACE provider associations also noted that some states require PACE organizations to submit a variety of data to NPA's DataPACE system. The system includes the following quality measure domains: rate of deaths, voluntary disenrollments, ED visits, fall rates, immunizations for influenza and pneumonia, and hospitalization admissions and number of days admitted. States can require PACE organizations to submit data to the NPA system, but the state cannot request the data directly from NPA. Officials in one state we interviewed noted they request the NPA data from each individual PACE organization in the state. In addition to broader quality measurement approaches, states also monitor specific indicators of program performance through required reporting.

Appeals and grievances. PACE organizations must submit data on appeals and grievances to CMS through the Health Plan Management System (HPMS). Most of the states interviewed review these quarterly data and do not impose any additional requirements around submission of appeal and grievance data. However, one state requires PACE organizations to directly report appeals and grievances to the state

using the state's templates. Another state requires real-time notification of service denials rather than the quarterly reporting of service denials in HPMS that the federal government requires.

Eligibility and disenrollment. All state interviewees reported deferring to federal requirements for PACE participant eligibility, with no PACE organizations including any additional eligibility requirements. Some states reported slight variation in their level of monitoring for involuntary and voluntary disenrollments. For example, in addition to the federal regulation requiring that PACE organizations report involuntary disenrollment in HPMS, one state also requires documentation demonstrating the steps taken before initiating an involuntary disenrollment. These steps may include efforts to address participant non-compliance or disruptive behavior as well as development of transition plans for alternative care arrangements.

CMS requires PACE organizations to report voluntary disenrollments in HPMS. CMS reviews this information, including the number of disenrollments and the reason for disenrollment, and discusses any trends on quarterly or monthly calls with PACE organizations. States also require PACE organizations to report disenrollment information, with varying timelines for review. One state requires PACE organizations to conduct exit surveys with individuals who voluntarily disenroll and then submit aggregated survey results annually to the state for analysis of patterns or trends in reasons for disenrollment. Another state reported that two common reasons for PACE disenrollment are enrollment in a Medicare Advantage plan and relocation outside of the PACE service area.

Data limitations and lack of standardization constrain oversight and comparability

States rely on a combination of federal and state data sources to support oversight of PACE organizations; however, stakeholders consistently noted that limitations in data availability and a lack of standardization constrain states' ability to assess outcomes and compare performance across programs. States use these data to monitor enrollment, utilization, and quality-related indicators but reported variation in how consistently data are accessed, analyzed, and applied to oversight activities.

Use of HPMS data for oversight. Officials from all states reported using data submitted by PACE organizations into HPMS as part of their monitoring processes. PACE organizations collect and submit quality reporting data to CMS on a quarterly basis, in accordance with federal regulations and CMS guidance (42 CFR 460) (CMS 2024d). These data include enrollment, appeals and grievances, ED visits, immunizations, medication administration errors, and a number of incidents that PACE organizations must report with a root cause analysis such as falls, infectious disease outbreaks, abuse, and adverse outcomes.[8] States request access to relevant HPMS modules and generally review the data during quarterly CMS-led meetings with PACE organizations. Federal officials indicated uncertainty about how many states regularly access HPMS or how the data are used for oversight purposes. Although state officials described reviewing these data as part of ongoing monitoring activities and discussions with PACE organizations, interviewees generally did not describe standardized processes for using the data to systematically identify performance concerns or trigger corrective actions.

Despite their use in oversight activities, PACE performance data are generally not publicly available, unlike Medicare managed care programs. For example, Medicare Advantage Star Ratings performance data for Medicare Advantage and Medicare Part D plans are publicly available through CMS's consumer-facing Medicare Plan Finder tool. PACE organizations are not included in the Plan Finder tool and are not subject to the Medicare Advantage Star Rating system (CMS 2025b). In addition, plan-specific or patient-level PACE data submitted through HPMS are restricted to authorized users. Federal officials confirmed that HPMS access requires a CMS-specific user ID and is limited to authorized Part D plans, states, and CMS staff.

Data limitations and challenges. Several states highlighted limitations to their ability to measure PACE organization performance and participant outcomes. For example, the state that implemented a VBP program noted that current state budget constraints and limited access to data that could be used to inform payment incentives have prevented the state from fully implementing the VBP program. Another state mentioned challenges identifying standard quality performance and outcome measures for PACE organizations and requested CMS's assistance developing standardized national PACE quality measures.

Several interviewees noted the tension between viewing PACE organizations as provider organizations or viewing them as payers. Federal officials and one state mentioned they aligned their approach to PACE oversight with managed care oversight, which can be helpful for creating efficiencies. However, PACE provider organizations and a national PACE expert highlighted the challenges of using a managed care approach for PACE oversight rather than an approach more suited to providers. Federal officials, a national expert, and a PACE association noted the challenges of applying managed care encounter data policies to capture the full range of services provided at PACE centers. Unlike traditional providers, a PACE enrollee may interact with multiple members of the interdisciplinary team during a single visit, each delivering a mix of services that could be covered under Medicare or Medicaid. As a result, capturing these interactions as standardized encounters—and fully reflecting the scope of services provided, including care coordination and other non–visit-based activities—can be challenging. Federal officials noted that CMS requires PACE organizations to submit additional data to the CMS encounter data system to fill in gaps that remain from encounter data reports. Two of the states interviewed also request that their PACE organizations submit encounter data to the state. Another state includes the option for the state to require encounter data reporting in its two-way program agreement but has not yet implemented the requirement because the state does not have the staff capacity to review and analyze the data. Federal officials also noted that one or two states have requested encounter data from CMS but were not sure of the extent to which the states were using the data.

As states and federal officials consider additional data sources to improve oversight and monitoring of PACE organizations' performance, one national expert noted that some opportunities are available in data already collected. For example, the interviewee noted that standardized assessments like the HCBS CAHPS survey or the I-SAT could provide meaningful insights into PACE participant experience and quality, although the small number of PACE participants creates challenges with data collection. The interviewee suggested that states and the federal government could consider creative use of existing data sources, such as Medicare Part D data for medication safety and hospital admissions data for falls.

State capacity constraints vary and are more pronounced in states monitoring performance

In our interviews with state officials, we found that states that focus more on monitoring compliance than on assessing performance are less likely to report concerns with capacity limitations. States with more and newer PACE organizations tended to report more constraints on available resources and capacity for oversight.

Of the six states interviewed, three reported adequate staffing capacity and bandwidth for overseeing and monitoring PACE organizations. Two of these states noted recent expansions in the number of PACE organizations operating in their state but did not raise any concerns about state capacity in light of these expansions. In contrast, three states mentioned concerns with limited state resources and capacity for conducting oversight, especially with rapid growth in the number of PACE organizations and increases in PACE enrollment in their states.

The variation in state oversight capacity reflects different perspectives of states' roles and responsibilities for oversight and monitoring. The three states that noted concerns with state capacity also reported that they monitor the performance of PACE organizations as well as their compliance with state and federal regulations, compared to some other states that tend to focus more on monitoring compliance only.

One state with capacity concerns noted that it is pausing its review of applications for new PACE organizations or service area expansions for the next two years. In this time, the state will review its PACE oversight process to determine if modifications are needed given the rapid expansion of PACE organizations. During this pause, the state is also considering opportunities to integrate PACE oversight with its overall oversight approach for the other integrated models, including D-SNPs, operating in the state. The state noted that it has also requested that CMS implement stricter federal application guidelines for new PACE organizations and service area expansions to close what the state described as loopholes that have allowed some organizations to submit multiple, simultaneous applications to a state.

Federal-State Coordination in Oversight

Oversight of PACE organizations is a shared responsibility between CMS and states, requiring coordination across multiple activities, including monitoring, audits, and data use. Although stakeholders consistently described this relationship as collaborative, they also identified variation in how coordination occurs in practice and highlighted opportunities to improve alignment between federal and state oversight efforts, particularly in areas such as audit processes.

Coordination practices

State and federal officials all agreed on the utility of the quarterly and monthly calls that CMS holds with states and PACE organizations. Federal officials noted that they set the agenda for these calls but regularly solicit input from states. Several states also mentioned the importance of working with CMS account managers who are assigned to individual PACE organizations and regularly participate in the quarterly and monthly calls as part of monitoring activities. However, one state suggested it was more of a listener than an active participant on quarterly calls with CMS and PACE organizations. Another state said the monthly and quarterly calls can be somewhat redundant, given similar state oversight activities, but were valuable opportunities for alignment and relationship-building with CMS and PACE organizations.

Federal oversight emphasizes compliance

Federal officials described their focus as monitoring compliance with requirements rather than advancing program quality. Federal officials explained that they become involved in quality-related issues occurring within individual PACE organizations, and these issues are discussed in quarterly and monthly calls with individual states and PACE organizations. Federal officials also expressed an interest in sharing more PACE data across states, including data trends, to better support coordinated oversight and the joint provision of targeted technical assistance with the goal of identifying and improving PACE organizations that may be poor performers.

Representatives from PACE associations discussed what they see as a federal focus on monitoring compliance rather than also assessing PACE organization performance and quality. As one PACE provider association commented, federal compliance protocols are not designed to capture how a PACE organization implements care planning and delivers care day to day. The PACE association highlighted federal and state gaps in oversight and monitoring, including standardized evaluation of care delivery, participant experience, and satisfaction. The PACE association suggested that the federal and state partnership to oversee PACE organizations could be structured so that federal oversight could focus on monitoring compliance and responding to challenges identified during the three-year trial period, while states could focus on monitoring operations and conducting oversight of quality of performance among PACE organizations beyond the trial period.

Misalignment and duplication in state and federal audits increase administrative burden

State and federal officials described changes in audit practices over time, particularly in the level of state involvement in federal audits and the frequency and timing of audit activities. These changes, combined with differences in how states conduct their own audits, have contributed to misalignment and duplication in oversight processes.

Changes in federal audit practices. Federal officials confirmed that CMS conducts three audits of PACE organizations during the initial three-year trial period for a PACE organization. A PACE provider association noted that the first federal audit during the trial period has evolved to become a consultative audit, through which CMS provides new PACE organizations with the opportunity to understand federal expectations for demonstrating compliance and helps them understand how CMS will conduct subsequent trial period audits.

All states and federal officials we interviewed discussed the evolution of the federal audit process and the effect on state involvement. Several states noted that before the COVID-19 pandemic, states regularly participated in CMS audits of PACE organizations; however, state and federal officials reported that federal audits are now conducted with limited state involvement. One state reported that CMS does not invite the state to participate in federal audits beyond being informed of the timing of the audit and potentially participating in a few calls during the audit process, a change in the typical prepandemic practice. However, one state noted that it attends and participates in CMS trial period audits, sitting in on daily calls with PACE organizations in which CMS auditors review documentation and findings. Federal and state officials also mentioned that states can access HPMS to review a summary of CMS audit findings. Federal officials noted that CMS invites states to participate in key discussions in the federal audit process but noted that states do not invite CMS to participate in state audit activities. Another state said CMS asks states to be mindful not to schedule state audits with a PACE organization near the time of a federal audit.

CMS does not have a set schedule for conducting routine audits after the trial period. Instead, CMS uses a risk assessment process to determine the need to conduct a routine audit with a PACE organization. Federal officials noted that the risk assessment includes a variety of factors, including a PACE organization's enrollment, growth, past audits, and information received from other entities within CMS. Federal officials also noted that a factor in determining the frequency of routine audits is based on availability of CMS resources and capacity. State interviewees noted an apparent decline in the frequency of routine CMS audits. One state noted that CMS had not conducted a routine audit of long-term PACE organizations in the state in the past five years. Another state official noted that there had been no CMS audits during her three-year tenure with the state agency that conducts PACE oversight.

Overlap between state and federal audits. Federal officials noted that they encourage states not to duplicate what CMS covers in the federal PACE audit process in the state audit. One state noted this request and reported that its state audits focus on monitoring compliance with state-specific regulations and requirements. Other states noted that information and data collected as part of their state audit processes replicate parts of the federal audit process. A PACE association also commented that states regularly audit aspects of PACE organization operations that overlap with federal audits, including level of care assessments, grievances, and serious disciplinary reports. However, the PACE association also noted that state audits in those areas are typically done on a smaller scale, with a review of only a handful of records, for example. The PACE association noted that PACE organizations often find that state monitoring and audits can help PACE organizations prepare for federal audits and encourage partnership and learning between the state and PACE organizations. Despite this, the state and federal audit processes can present challenges, particularly in terms of timing. In some cases, a federal audit is followed by a state audit within weeks, or the reverse, which can lead to challenges for the PACE organization and its ability to be fully responsive to audit-related data collection requests. Some states suggested there could be an opportunity to partner with federal officials to conduct audits together or better align the audits.

Opportunities for improved coordination

In addition to concerns about duplication in state and federal audits, one state commented on the opportunity for federal officials to streamline data sharing with states. The state noted that because they do not have visibility into Medicare data (e.g., Medicare capitation payments), they cannot get a complete assessment of PACE organizations' financial

stability and other aspects of their performance and operations that are primarily Medicare focused.

PACE provider associations noted gaps in federal and state oversight activities. One provider association noted a lack of federal or state technical assistance to PACE organizations to improve operations and performance. The PACE association noted that PACE organizations tend to improve their performance in response to an incident, when they develop and implement CAPs, rather than before an incident occurs. The PACE association suggested that additional state and federal technical assistance could help PACE organizations shift from this reactive approach to a proactive one. The association also noted that there are opportunities for states to support new PACE organizations before their launch to help them meet state and federal requirements.

Commission Recommendations

The Commission makes three recommendations to CMS to improve coordination between state and federal oversight of PACE organizations and to increase transparency of PACE program performance. Together, these recommendations address key challenges identified in this chapter, including duplication in oversight activities, limited access to performance data, and the absence of standardized quality measures.

Recommendation 6.1

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to update audit protocols and three-way program agreements to facilitate joint audits of Program of All-Inclusive Care for the Elderly organizations with state administering agencies. Audit coordination should include joint planning of audit scopes, sharing documentation requests, and reviewing evidence concurrently, while preserving CMS's responsibility for assessing federal requirements and states' responsibility for assessing state-specific requirements.

Rationale

This recommendation addresses coordination challenges between CMS and states in overseeing PACE organizations identified by stakeholders, particularly related to overlapping audit activities and limited sharing of oversight findings and data. Sections 1934(e)(4)(A) and (B) of the Act and regulations at 42 CFR 460.190 and 192 require CMS to cooperate with the SAA in evaluating PACE organizations during the first three years of a program's trial period and periodically thereafter. Statute further specifies that reviews conducted during the PACE organization's trial period must assess the organization's PACE center, fiscal soundness, capacity to provide all PACE services to all enrolled participants, compliance with important statutory and regulatory requirements, and any other elements that CMS or the SAA considers necessary.

Despite these requirements, regulations describing federal and state monitoring under 42 CFR 460 subpart K do not clearly differentiate roles for CMS and states, only stating that CMS monitoring is "in cooperation with the state administering agency." Nor does policy guidance in CMS's PACE manual and publicly available three-way program agreement template language elaborate on how CMS and SAAs should coordinate trial period or ongoing oversight (CMS 2011, 2000).

Across both phases of interviews, federal and state officials described audits as the central mechanism for overseeing PACE organizations. CMS audits assess several areas, including compliance and quality improvement, and involve reviewing whether organizations collect and analyze required quality data and take corrective action when necessary. States also rely heavily on audits to monitor PACE organizations, although the frequency and scope of these reviews vary across states.

Existing systems and requirements suggest that CMS and states are well positioned to share audit documentation and oversight data systematically. For example, CMS currently provides states access to several data modules within HPMS upon request. CMS could potentially use the system to automatically share audit results and supporting documentation with appropriate redactions to protect participant privacy with states, rather than only summaries of findings. In addition, CMS and states are required under 42 CFR

460.196 to promptly report audit results to the PACE organization along with any recommendations for program changes, indicating that processes already exist for communicating audit findings.

Under this recommendation, joint audits would go beyond aligning audit timing to include coordination in audit design and execution. For example, CMS and states should jointly plan audit scopes, share documentation requests, conduct joint entrance and exit conferences with PACE organizations, and review evidence concurrently. Coordinated audit approaches could allow CMS and states to assess overlapping federal and state requirements at the same time—particularly where state requirements closely mirror federal requirements—reducing duplicative review and administrative burden for both PACE organizations and oversight entities. CMS would continue to assess compliance with federal requirements, while states would retain responsibility for evaluating compliance with state-specific requirements. Joint audits could also enhance visibility across oversight entities by facilitating more systematic sharing of information on issues that may be more readily identified at one level, such as enrollment concerns or grievances reported to states, and support the development of aligned or complementary findings where appropriate, while allowing for independent determinations when federal and state priorities differ.

This recommendation does not assume that CMS would assess compliance with state-specific requirements or that states would assess compliance with federal requirements beyond their existing roles. Rather, it is intended to improve transparency and reduce duplication by ensuring that both entities have access to relevant information and a shared understanding of PACE organization performance. Such coordination would not preclude CMS or states from conducting independent oversight activities when necessary (e.g., responding to complaints or performance concerns), and states could continue to conduct audits more frequently than CMS, with coordination occurring when federal audits take place. This approach would establish formal expectations for coordination while allowing flexibility for CMS and states to determine when joint audits are feasible based on resources, program size, and other considerations.

Implications

Federal spending. The Congressional Budget Office (CBO) estimates this recommendation would not have a direct effect on federal Medicaid spending.

States. Greater coordination with CMS would reduce duplication in oversight activities and improve states' access to federal audit findings.

PACE organizations. Coordinated audits would reduce the administrative burden associated with preparing for and responding to multiple oversight reviews. More coordinated oversight, such as joint audits or shared review processes, would reduce duplicative information requests and streamline corrective action processes.

Enrollees. To the extent that improved coordination allows CMS and states to more effectively identify compliance issues or performance concerns, it would strengthen oversight of PACE organizations and help ensure participants receive services and care.

Recommendation 6.2

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to aggregate and publicly release, in a user-friendly format on the CMS website, existing Program of All-Inclusive Care for the Elderly (PACE) performance data, including data PACE organizations submit through CMS's Health Plan Management System as well as enrollee satisfaction data collected as part of PACE organization quality improvement programs pursuant to 42 CFR 460.134(a)(2).

Rationale

This recommendation addresses the limited availability and accessibility of PACE performance data identified in our findings. Greater transparency in PACE performance data would help beneficiaries, caregivers, policymakers, and researchers better understand PACE program performance and compare it with other long-term services and supports (LTSS) options, which is not currently possible. PACE organizations already report a range of performance data to CMS through HPMS—including information on enrollment;

grievances and appeals; ED utilization; and reportable incidents such as falls, infections, and other adverse events—yet these data are not publicly accessible. In contrast, CMS routinely publishes performance information for other Medicare and Medicaid plans, allowing beneficiaries and policymakers to compare plan performance. PACE organizations are not meaningfully included in these public reporting systems. Publicly available data would support more informed beneficiary and caregiver decision making about whether to enroll in PACE, including in areas with multiple PACE programs. Researchers and policymakers would be able to evaluate the PACE model and its outcomes. In addition, PACE data could enable states to benchmark performance across PACE programs, helping them to identify recurring challenges, emerging trends, or gaps in oversight practices. A standardized dataset or dashboard could allow states to compare programs on measures such as participant outcomes, grievances, or reportable incidents, similar to approaches used in other managed care programs. Currently, these data are primarily used for internal oversight, with CMS, states, and PACE organizations addressing issues on a case-by-case basis through mechanisms such as CAPs. Aggregated, publicly accessible data would allow CMS, states, and other stakeholders like beneficiary advocates and provider associations to identify trends more easily and address any challenges with more systemic policy changes, in addition to individual corrective actions. Public-facing performance data would also provide incentives for PACE organizations' quality improvement.

This recommendation would deliver these benefits with a limited burden on CMS, states, and PACE organizations because it would rely on existing data submissions. Although CMS may need to ready existing data for public release, this option would not require the creation of new reporting requirements or additional data collection from PACE organizations. CMS could initially focus on publicly reporting a limited set of existing indicators or summary statistics to improve transparency while minimizing burden and expand reporting over time as appropriate. For instance, CMS may work toward standardizing the use of the I-SAT survey for PACE organizations, given that the vast majority of PACE organizations already use this tool. PACE organizations may also need to work with CMS and states to ensure that reported data are presented in ways that accurately reflect the unique characteristics of the PACE model and the populations it serves and to ensure consistent reporting practices. We recognize that data aggregated at the PACE organization level may have limitations for researchers and policymakers, and individual-level data may be needed to adjust for differences in PACE populations. CMS may work toward collection of individual-level data as a next step in its monitoring and reporting.

Implications

Federal spending. CBO estimates this recommendation would not have a direct effect on federal Medicaid spending.

States. States would benefit from improved access to information about PACE program performance, particularly in states with multiple PACE organizations. Public reporting would also support state oversight activities by providing a clearer view of program performance trends and allowing states to compare outcomes across programs. States may also need to coordinate with CMS to ensure that publicly reported data align with existing state reporting requirements and oversight processes.

PACE organizations. Public reporting would provide PACE organizations with additional opportunities to demonstrate program performance of the PACE model.

Enrollees. Greater transparency around PACE program performance would help beneficiaries and caregivers better understand the services offered by PACE organizations and how the program compares with other LTSS options.

Recommendation 6.3

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to amend regulations at 42 CFR 460 Subpart H to develop a standardized, national quality measure set for Program of All-Inclusive Care for the Elderly (PACE) organizations. Quality data should be compiled and made publicly available in an accessible format. CMS should follow three key principles when developing a PACE quality measure set: engage stakeholders

collaboratively; minimize reporting burden by focusing on the most meaningful measures; and prioritize standardized measures that enable comparability across programs where feasible.

Rationale

This recommendation addresses the absence of standardized quality measures and challenges in comparing PACE program performance across states. In the first phase of our PACE work, nearly all stakeholders we interviewed expressed interest in the development of a standardized national PACE quality measure set that would allow for comparisons within and across states. PACE organizations expressed a desire to have uniformity in quality measures across states, which they said would allow for easier expansion across states. CMS officials shared that they previously undertook a project to develop PACE quality standards, but questions of whether measures would be comparable across PACE organizations nationally hindered the project's success. Standardized measures would need to be applicable for PACE programs of various sizes and with different patient mixes, a potential challenge in creating a standardized national measure set. However, our findings suggest that progress has been made toward developing standardized PACE measures. Some states, including New York and California, have incorporated state-specific quality improvement, reporting, and performance monitoring requirements into their PACE oversight frameworks. For example, California requires PACE organizations to use measurable quality indicators and report outcomes from quality improvement projects and consumer satisfaction surveys, while New York requires reporting on grievances and appeals, annual performance improvement projects, and enrollee functional status data. NPA also noted it is conducting ongoing work to develop a standardized measure set and a PACE performance recognition program through their Alliance for PACE Innovation and Quality and highlighted DataPACE, a voluntary dataset that NPA produces with data that PACE organizations submit on enrollee characteristics and utilization.[9]

A renewed CMS effort to create standardized PACE quality measures would build on this existing work while addressing persistent gaps in comparability and oversight. Although states and PACE organizations have made progress, the absence of a federally required, standardized measure set continues to limit CMS's and states' ability to assess program performance consistently, compare outcomes across PACE organizations and states, and identify systemic quality issues. CMS is well positioned to act as a convener to gather both information on existing quality measurement efforts and input on a new comprehensive quality approach because of the regular meetings it hosts with states and PACE organizations. Given challenges related to comparability across PACE organizations, CMS should work closely with quality measurement and PACE experts to implement this option.

CMS has created a standardized national HCBS quality measure set, which can serve as an example for development of a standardized national PACE quality measure set. CMS noted the intent of the HCBS measure set was to create opportunities for CMS and states to have comparative quality data on HCBS programs (CMS 2022). The development of the HCBS measure set suggests it is feasible to develop a standardized measure set even with small population sizes and programs that vary across states. This option includes a similar aim for PACE.

Quality measurement principles for PACE

Based on our findings and rationale outlined above, we identified the following principles for a national PACE measure set:

- **Collaborative.** CMS should develop the PACE quality measure set with input from states, PACE organizations, PACE participants and their families or caregivers, quality experts, researchers, and other stakeholders. Because the PACE population is small and has a narrow set of demographic characteristics, yet varies across states and PACE organizations, gathering meaningful stakeholder feedback on an overall PACE quality measurement approach as well as specific quality measures to include should be a priority for CMS.
- **Minimizes burden.** CMS should aim to minimize burden for PACE organizations in developing a standardized quality measure set. Quality measures should be limited to the

most meaningful health outcome and enrollee satisfaction measures that reflect stakeholder priorities and the demographics and needs of the PACE population.

- **Sets priorities for comparability where possible.** Both our interview findings and feedback from Commissioners raised the issue of a lack of ability to compare outcomes across various programs serving dually eligible individuals, including Medicare Advantage D-SNPs. Quality measures used in other managed care programs serving dually eligible individuals may be challenging to apply to PACE, given the relatively small size of the PACE program and the LTSS needs of PACE participants. CMS will need to balance this challenge with the need for comparability across programs. CMS should set priorities, including quality measures, that are also used in Medicare Advantage Star Ratings, Medicaid, and other programs serving dually eligible individuals, such as HEDIS and CAHPS measures, to allow for an apples-to-apples comparison where possible. CMS should also look to its recent development of the HCBS quality measure set, given some similarities in the populations.

Implications

Federal spending. CBO estimates this recommendation would not have a direct effect on federal Medicaid spending.

States. Many states already collect a variety of data from PACE organizations that may duplicate or overlap with existing federal reporting requirements. Creating a standardized national quality measure set would reduce burden and confusion for states by creating a clear baseline of reporting that all PACE organizations across all states would be required to submit to CMS and states. States would no longer need to create their own quality measures to gather information about PACE organization performance, for instance. However, states would retain the flexibility of requiring additional state-specific reporting from PACE organizations if they choose to through their two-way agreement, state regulations, or other state policy tools.

States would be able to better compare performance across PACE organizations within and across states. This would allow states to focus on quality improvement with PACE organizations, as indicated by performance data, and to provide incentives for improved performance through initiatives like VBP programs.

PACE organizations. This recommendation would likely create some initial burden for PACE organizations as they adjust to new reporting requirements.

Enrollees. PACE enrollees would likely not see an immediate impact to their day-to-day care with this option. However, with full implementation of this option, enrollees should see improvements in quality of care as PACE organizations are encouraged to improve quality measure outcomes, particularly with public reporting. Prospective PACE enrollees and their family members or caregivers may also benefit, with more transparent information about PACE organization performance and outcomes to inform their choices. Depending on whether standardized PACE quality measures include some measures in common with other LTSS programs, they may be able to make comparisons across programs as well.

Looking Ahead

States' varied oversight approaches to PACE programs highlight the importance of promoting greater consistency and coordination while preserving flexibility for state Medicaid programs to address local needs. The Commission is committed to improving access to HCBS and integrated care for dually eligible beneficiaries, which is reflected in this multicycle work on PACE. While this work is concluding, staff will continue to examine how federal and state Medicaid policies, along with coordination between CMS and states, support oversight and transparency across integrated care models.

Endnotes

[1] PACE participants are not required to be able to live safely in the community after enrollment as a condition for continuing enrollment, per 42 CFR 460.160.

[2] For further reading, see studies finding that PACE participants generally experience lower rates of hospitalization, nursing facility use, and mortality compared to similar populations, despite having higher levels of medical complexity and functional need (Feng et al. 2021, Segelman et al. 2017, Meunier et al. 2016, Ghosh et al. 2015, JEN Associates 2015, Segelman et al. 2014, Meret-Hanke 2011, Wieland et al. 2010, Beauchamp et al. 2008). Additional research suggests that the PACE interdisciplinary team model may support improved behavioral health outcomes and more culturally responsive care (Travers et al. 2022, Vouri et al. 2015, Ginsburg and Eng 2009).

[3] Medicare and Medicaid oversight are required for any PACE program, regardless of participant makeup, given its status as a program under both Sections 1894 and 1934 of the Social Security Act.

[4] The Medicare-Medicaid Plans ended on December 31, 2025, with the sunset of the Financial Alignment Initiative demonstration.

[5] To be eligible for PACE, an individual must be 55 years or older, meet the nursing facility level of care requirement in their respective state, live within the service area of a PACE organization, and be able to live safely in the community at the time of enrollment. Importantly, eligibility for PACE is not restricted to dually eligible individuals. A PACE enrollee may be eligible for Medicaid, Medicare, both, or neither (42 CFR 460.150(d)).

[6] CMS annual enrollment data report that enrollment are for full-benefit dually eligible beneficiaries and a combined total of Medicaid-only and dually eligible beneficiaries enrolled in PACE (CMS 2024a). CMS monthly enrollment data are reported by Medicare Part D contract and may include both dually eligible and Medicare-only PACE participants (CMS 2026). These data sources do not separately identify Medicare-only enrollment, but prior analyses suggest Medicare-only enrollees account for less than 1 percent of total PACE enrollment (NPA 2023).

[7] Under Section 1934(e)(8) of the Act, any application for PACE program provider status is deemed approved if CMS does not deny the application or request additional information within 90 days of submission. If CMS requests additional information, the application is deemed approved unless CMS denies it within 90 days after receiving the requested information.

[8] The full list of incidents that PACE organizations are required to report to CMS through HPMS includes abuse incidents, appeals, adverse drug reactions, adverse outcomes, second-degree or higher burns, elopements, ED or urgent care visits, enrollment data, equipment-related occurrences, falls (with and without injury), fires or other disasters, foodborne outbreaks, grievances, immunizations, infectious disease outbreaks, media-related events, medication administration errors (with and without an adverse effect), motor vehicle accidents, pressure injuries, restraint use, suicide attempts or suicides, and unexpected deaths (CMS 2024d).

[9] The Alliance for PACE Innovation and Quality is an affiliated organization of the NPA and provides support for PACE organizations in increasing enrollment and improving operational performance as well as evaluating and recognizing PACE organizations for quality performance.

References

Beauchamp, J., V. Cheh, R. Schmitz, et al. 2008. *The effect of the Program of All-Inclusive Care for the Elderly (PACE) on quality*. Report to CMS, contract no. 500-00-0033(01). Princeton, NJ: Mathematica Policy Research. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/reports/downloads/beauchamp_2008.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2026. Medicare Advantage/Part D contract and enrollment data: Monthly enrollment by contract. Baltimore, MD: CMS. https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/monthly-enrollment-contract.

Center for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2025a. *Medicare-Medicaid Coordination Office: Fiscal year 2024 report to Congress*. Baltimore, MD: CMS. https://www.cms.gov/files/document/mmco-report-congress.pdf-0.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2025b.

Medicare 2026 Part C & D Star Ratings technical notes. Baltimore, MD: CMS. https://www.cms.gov/files/document/2026-star-ratings-technical-notes.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024a. Enrollment report: 2024 Managed care enrollment data. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/managed-care/enrollment-report.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024b. Medicare program; changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for contract year 2024—remaining provisions and contract year 2025 policy and technical changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE). Final rule. *Federal Register* 89, no. 79 (April 23): 30448–30848. https://www.federalregister.gov/documents/2024/04/23/2024-07105/medicare-program-changes-to-the-medicare-advantage-and-the-medicare-prescription-drug-benefit.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024c. BIPA 903 waiver requests. Baltimore, MD: CMS. https://www.cms.gov/medicare/health-plans/pace/bipa903waiverrequests.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024d. *PACE quality data monitoring & reporting guidance*. Baltimore, MD: CMS. https://www.cms.gov/files/document/pace-quality-monitoring-and-reporting-guidancejanuary-2024.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023. Letter from Amy Larrick Chavez-Valdez, Kathryn A. Coleman, and Jennifer R. Shapiro to all Medicare Advantage, cost plans, demonstrations, and PACE organizations regarding "Reporting requirements for HEDIS Measurement Year (MY) 2023, HOS, and CAHPS measures, and information regarding HOS and HOS-M for frailty." May 15, 2023. https://www.cms.gov/files/document/2024reportingrequirementsforhedishosandcahps5152023g.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022. Letter from Daniel Tsai to state Medicaid directors regarding "Home and community-based services quality measure set. July 21, 2022. https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. Medicare and Medicaid programs; Programs of All-Inclusive Care for the Elderly (PACE). Final rule. *Federal Register* 84, no. 106 (June 3): 25610–25677. https://www.federalregister.gov/documents/2019/06/03/2019-11087/medicare-and-medicaid-programs-programs-of-all-inclusive-care-for-the-elderly-pace.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2011. Programs of All Inclusive Care for the Elderly (PACE) manual. Baltimore, MD: CMS. https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms019036.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2000. PACE program agreement. Baltimore, MD: CMS. https://www.cms.gov/medicare/health-plans/pace/downloads/programagreement.pdf.

Colorado Department of Health Care Policy & Financing (HCPF). 2021. Program of All-Inclusive Care for the Elderly (PACE) manual. Denver, CO: HCPF. https://hcpf.colorado.gov/pace-manual.

Feng, Z., J. Wang, A. Gadaska, et al. 2021. *Comparing outcomes for dual eligible beneficiaries in integrated care: Final report*. Report to the Office of Behavioral Health, Disability, and Aging Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, contract no. HHSP233201600021I. Research Triangle Park, NC: RTI International. https://aspe.hhs.gov/sites/default/files/documents/9739cab65ad0221a66ebe45463d10d37/dual-eligible-beneficiaries-integrated-care.pdf.

Ghosh, A., R. Schmitz, and R. Brown. 2015. *Effect of PACE on costs, nursing home admissions, and mortality: 2006–2011*. Report to Office of Disability, Aging, and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, contract no. HHSP23320095642WC. Princeton, NJ: Mathematica Policy Research. https://aspe.hhs.gov/sites/default/files/private/pdf/76971/PACEeffect_0.pdf.

Ginsburg, I.F., and C. Eng. 2009. On-site mental health services for PACE (Program of All-Inclusive Care for the Elderly) centers. *Journal of the American Medical Directors Association* 10, no. 4: 277–280. https://pubmed.ncbi.nlm.nih.gov/19426945/.

Integrated Care Resource Center (ICRC). 2025. *Monthly integrated care exclusively aligned enrollment report: Dually eligible individuals enrolled in Medicare-Medicaid plans (MMPs), Programs of All-Inclusive Care for the Elderly (PACE), and Applicable Integrated Plans (AIPs)*. Washington, DC: ICRC. https://www.integratedcareresourcecenter.com/resource/monthly-integrated-care-exclusively-aligned-enrollment-report-dually-eligible-individuals.

JEN Associates. 2015. *Massachusetts PACE evaluation nursing facility residency and mortality summary report*. Cambridge, MA: JEN Associates. https://www.mass.gov/doc/massachusetts-pace-evaluation-nursing-facility-residency-and-mortality-summary-report-112315-0/download.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2025. Chapter 4: Understanding the Program of All-Inclusive Care for the Elderly. In *Report to Congress on Medicaid and CHIP*. June 2025. Washington, DC: MACPAC. https://www.macpac.gov/publication/understanding-the-program-of-all-inclusive-care-for-the-elderly/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020. Chapter 1: Integrating care for dually eligible beneficiaries: Background and context. In *Report to Congress on Medicaid and CHIP*. June 2020. Washington, DC: MACPAC. https://www.macpac.gov/publication/chapter-1-integrating-care-for-dually-eligible-beneficiaries-background-and-context/.

Meret-Hanke, L.A. 2011. Effects of the Program of All-Inclusive Care for the Elderly on hospital use. *The Gerontologist 51*, no. 6: 774–785. https://academic.oup.com/gerontologist/article-abstract/51/6/774/817014?redirectedFrom=fulltext.

Meunier, M.J., J.M. Brant, S. Audet, et al. 2016. Life after PACE (Program of All-Inclusive Care for the Elderly): A retrospective/prospective, qualitative analysis of the impact of closing a nurse practitioner centered PACE site. *Journal of the American Association of Nurse Practitioners* 28, no. 11: 596–603. https://pubmed.ncbi.nlm.nih.gov/27232590/.

National Pace Association (NPA). 2026. Find a PACE program near you. Alexandria, VA: NPA. https://www.npaonline.org/find-a-pace-program.

National PACE Association (NPA). 2023. Pass the PACE Part D Choice Act: Ensure affordable prescription drug coverage for Medicare beneficiaries. Alexandria, VA: NPA. https://www.npaonline.org/docs/default-source/default-document-library/issue-brief-support-the-pace-part-d-choice-act.pdf?sfvrsn=60f032fd_1.

National PACE Association (NPA). 2019. PACE: Frequently asked questions. Alexandria, VA: NPA. https://www.npaonline.org/docs/default-source/uploadedfiles/pace-faqs-oct-2019-pdf.pdf?sfvrsn=1579acc6_0.

Segelman, M.A., X. Cai, C. van Reenen, and H. Temkin-Greener. 2017. Transitioning from community-based to institutional long-term care: Comparing 1915(c) waiver and PACE enrollees. *The Gerontologist* 57, no. 2: 300–308. https://academic.oup.com/gerontologist/article-abstract/57/2/300/2631971?redirectedFrom=fulltext.

Segelman, M., J. Szydlowski, B. Kinosian, et al. 2014. Hospitalizations in the Program of All-Inclusive Care for the Elderly. *Journal of the American Geriatrics Society* 62, no. 2: 320–324. https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.12637.

Travers J.L., S. D'Arpino, C. Bradway, et al. 2022. Minority older adults' access to and use of Programs of All-Inclusive Care for the Elderly. *Journal of Aging & Social Policy* 34, no. 6: 976–1002. https://pmc.ncbi.nlm.nih.gov/articles/PMC9357232/.

Vouri, S.M., S.M. Seaton, S. Sutcliffe, and S. Austin. 2015. Changes in mood in new enrollees at a Program of All-Inclusive Care for the Elderly (PACE). *Consultant Pharmacist* 30, no. 8: 463–471. https://pmc.ncbi.nlm.nih.gov/articles/PMC4605402/pdf/nihms726742.pdf.

Wieland, D., R. Boland, J. Baskins, and B. Kinosian. 2010. Five-year survival in a Program of All-Inclusive Care for Elderly compared with alternative institutional and home- and community-based care. *The Journals of Gerontology: Series A* 65A, no. 7: 721–726. https://academic.oup.com/biomedgerontology/article-abstract/65A/7/721/560137.

APPENDIX 6A: Detailed Review of State Two-Way Program Agreements

Some states operate two-way program agreements between the state administering agency (SAA) and Program of All-Inclusive Care for the Elderly (PACE) organizations. Among the 33 states and the District of Columbia with active PACE programs, 16 states and the District of Columbia reported using two-way program agreements, and 3 additional states reported that they are developing them. Washington, which is included in the 16-state count, uses a two-way program agreement alongside state statutory provisions. Missouri is not included in the 16-state count because it no longer maintains an active two-way agreement; however, Missouri was included in this analysis because its state law codified PACE requirements based on a previous two-way agreement framework.

The two-way program agreements we reviewed include both standardized templates and executed contracts with PACE organizations. These agreements vary widely in length, ranging from 4 pages (Missouri's statute and New Mexico's agreement) to 298 pages (Washington), with a median length of 43 pages. They also vary in duration and renewal structure. Some specify fixed performance periods (one-year terms in New York and Colorado), while others span multiple years (such as North Dakota's 2025–2027 agreement). Four other states (Colorado, New Mexico, Tennessee, and Wisconsin) also shared contract language dated 2025, but it is unclear how frequently states update or amend these agreements. Virginia originally issued its two-way program agreement in 2007 and subsequently updated it several times but allows extensions unless either the PACE organization or the SAA provides notice to terminate. Two-way program agreements from at least four other states (California, Colorado, North Dakota, and New York) include provisions for extensions of varying durations and frequencies.

States generally use two-way program agreements to supplement the federal oversight framework by incorporating state-specific requirements and providing additional operational details. These agreements most often address areas already identified in the three-way program agreement but expand on them through additional specificity or reporting requirements: (1) trial period monitoring; (2) ongoing monitoring requirements; (3) corrective action plans (CAPs); (4) enrollee level of care redeterminations; and (5) reporting on quality, financial performance, and encounter data (Table 6A-1). However, states rarely use these agreements to substantively modify or expand the statutory role of the SAA.

TABLE 6A-1. Use of Program of All-Inclusive Care for the Elderly Two-Way Program Agreements by Category and State

Category	States
Trial period monitoring	CA, ND, VA
Ongoing monitoring (after trial)	CA, CO, DC, KS, MA, MI, MO, ND, NM, NY, OH, PA, RI, TN, WA, WI
Corrective action plan requirements	CA, CO, MA, ND, OH, PA, TN, VA, WI
Level of care redeterminations (adds detail)	CA, ND, NY, OH, TN, WI
Reporting requirements	
Grievances and appeals	CA, MA, MI, NY, TN, VA, WI
Enrollments	CA, CO, MI, ND, TN, WI
Disenrollments	CA, CO, ND, TN, WI
Incidents	CA, CO, OH, TN

TABLE 6A-1. (continued)

Category	States
Enrollment denials	CO, ND
Media events	CO
Financial data	CA, CO, KS, MI, NM, NY, PA, VA, WI
Quality improvement plans	CA, MA, MI, ND, NY, OH, PA, TN
Encounter data	CA, CO, ND, NY, OH, TN, WI
Service utilization data	CA, KS, MA, NM, OH
Fraud and abuse	ND, NY, OH, VA, WI
Statistical data	CA, MA, ND, NM
Provider listings	CA, MI, MO, TN
Other/miscellaneous	CA, MA, MI, TN, ND
Additional SAA roles	
Marketing materials/plan review	CA, MA, OH, TN
Outreach/beneficiary education	CA, KS, WI
Clinical operations	MI
Technical assistance/administrative support	CA, WI

Notes: SAA is state administering agency. Missouri's provisions appear in state statute, reflecting a prior two-way program agreement.

Source: MACPAC, 2026, analysis of two-way program agreements submitted by states.

Detailed findings by category

Trial period monitoring. Federal regulations and the three-way program agreement require the Centers for Medicare & Medicaid Services (CMS) and the SAA to conduct comprehensive annual reviews of PACE organizations during the trial period to ensure compliance with program requirements (42 CFR 460.190). These reviews include on-site visits, assessments of compliance, fiscal soundness, organizational capacity, and other operational elements. In practice, only three states explicitly address trial period monitoring in their two-way program agreements. California and North Dakota allow the SAA to request additional data from PACE organizations to support monitoring, while Virginia requires quarterly financial statements comparing budgeted versus actual spending reports.

Ongoing monitoring requirements. Federal regulations and the three-way program agreement provide limited specificity regarding states' roles in the ongoing monitoring of PACE organizations (42 CFR 460.192). For example, 42 CFR 460.192(a) states that the SAA, in cooperation with CMS, will continue to conduct reviews as appropriate, considering quality of care and compliance with state and federal requirements, following the trial period. Similarly, 42 CFR 460.192(b) indicates that SAAs and CMS will jointly conduct reviews as appropriate, based on a risk assessment of the PACE organization's performance and regulatory compliance.

All of the two-way program agreements that we reviewed, with the exception of Virginia's, include provisions addressing ongoing monitoring after the trial period. However, these provisions are generally broad and only modestly expand on the requirements in the three-way program agreement. For example, nine states (Colorado, Kansas, Massachusetts, New Mexico, New York, North Dakota, Ohio, Washington, and Wisconsin) require PACE organizations to retain records for specified periods.

All two-way program agreements reviewed besides Virginia's also require PACE organizations to make records and facilities available for state review or inspection, with some states specifying the scope of these reviews. Missouri's statute, for instance, outlines both remote and on-site audit activities, which may include reviews of enrollee files, grievance and appeals logs, service and call logs, personnel files, and observations of enrollees and organizational compliance with policies and procedures. Pennsylvania's agreement similarly notes that monitoring activities may include on-site visits, including to PACE enrollees' homes.

Most two-way program agreements do not clearly articulate the goals or objectives of ongoing monitoring, with the exception of Massachusetts and Michigan. Massachusetts's two-way program agreement specifies that monitoring is intended to (1) annually assess the impact and effectiveness of the PACE organization's Quality Assurance and Performance Improvement plan; (2) evaluate compliance with the two-way program agreement; and (3) assess, in conjunction with CMS, the quality, appropriateness, and timeliness of services. Michigan conducts annual on-site reviews of administrative processes, financial management, provider networks, covered services, quality assurance, utilization review, data reporting, claims processing, and documentation. Its two-way program agreement identifies 15 specific performance measures.

CAPs. A CAP is one of three types of compliance actions that CMS may take based on the type of non-compliance (the other two being issuance of a notice of non-compliance or a warning letter). CAPs are issued for particularly serious or continued non-compliance with PACE requirements (42 CFR 460.119(c)). Federal regulations require PACE organizations to correct deficiencies identified by CMS or the state, with both parties responsible for monitoring CAP effectiveness (42 CFR 460.194). Nine states (California, Colorado, Massachusetts, North Dakota, Ohio, Pennsylvania, Tennessee, Virginia, and Wisconsin) specify additional CAP requirements in two-way program agreements. Two states (North Dakota and Tennessee) define time frames for developing CAPs. Five other states (California, Massachusetts, North Dakota, Ohio, and Virginia) outline enforcement actions if CAPs are inadequate, such as imposing sanctions, withholding payments, suspending agreements, or terminating programs.

Three states use two-way program agreements to take a more active role in monitoring CAPs. Ohio and Pennsylvania require PACE organizations to submit an annual written Quality Management Activities Report that includes an evaluation of implemented CAPs. Ohio further specifies that CAPs must identify the root causes of deficiencies; outline goals, objectives, methodologies, and corrective actions; and designate responsible PACE organization staff to achieve compliance within set time frames. Wisconsin's two-way program agreement allows the state to impose "intensive oversight" to bring a PACE organization into compliance, which may include placing state staff or designated representatives on site to provide technical guidance and support corrective actions.

Enrollee level of care redeterminations. Federal regulations assign states primary responsibility for conducting annual level of care redeterminations for PACE enrollees (42 CFR 460.160(b)). Six states (California, New York, North Dakota, Ohio, Tennessee, and Wisconsin) add details to this process in their two-way program agreements with PACE organizations. Ohio, Tennessee, and Wisconsin also establish specific time frames for completing redeterminations, such as within 30 days before the due date (Tennessee) or within 365 days of the most recent determination (Ohio and Wisconsin).

Several states delegate responsibility for completing level of care redeterminations to PACE organizations. North Dakota requires PACE organizations to use the state's Level of Care Check tool, which includes eight elements, while New York requires use of a state-developed redetermination tool. Tennessee does not require a specific tool but mandates that qualified assessors who have completed the state's home- and community-based services qualified assessor training conduct redeterminations. In Ohio, PACE organizations conduct redeterminations, but the state retains responsibility for validating all level of care determinations and requires PACE organizations to submit requests for determinations and redeterminations no later than seven business days before the due date.

Federal regulations allow states to waive annual level of care redeterminations when they determine that an enrollee's condition is unlikely to improve or change substantially due to the severity of a chronic condition or functional impairment (42 CFR 460.160(b)(2)). Tennessee is the only state whose two-way program agreement allows the state to waive the annual recertification requirement for specified conditions, including Alzheimer's disease or related dementias, chronic obstructive pulmonary disease, end-stage renal disease, and congestive heart failure.

Reporting. Federal regulations require PACE organizations to collect and report data, maintain records, and provide CMS and states access to specified enrollee, financial, and medical records (42 CFR 460.200, 460.204, and 460.70). CMS requires PACE organizations to submit quarterly data on 24 quality measures through the Health Plan Management System (HPMS). These measures cover both administrative processes, such as appeals, grievances, enrollments, disenrollments, and enrollment denials, and reportable incidents requiring investigation, including unexpected deaths, infectious disease outbreaks, and falls resulting in injury or serious trauma.[3]

State two-way program agreements require PACE organizations to submit a range of data and reports, including both measures already reported to CMS through HPMS and additional state-specific requirements. The quality- related reports states most commonly require that also overlap with HPMS submissions include grievances and appeals reports (seven states: California, Massachusetts, Michigan, New York, Tennessee, Virginia, and Wisconsin), enrollment reports (six states: California, Colorado, Michigan, North Dakota, Tennessee, and Wisconsin), disenrollment reports (five states: California, Colorado, North Dakota, Tennessee, and Wisconsin), incident reports (four states: California, Colorado, Ohio, and Tennessee), enrollment denials (two states: Colorado and North Dakota), and media event reports (one state: Colorado).

States also require PACE organizations to submit financial reports through mechanisms separate from HPMS. During the trial period, PACE organizations must submit quarterly financial statements to CMS, and after the trial period, CMS or states may require quarterly or monthly financial reporting. PACE organizations must also submit annual certified financial statements to CMS. Nine states (California, Colorado, Kansas, Michigan, New Mexico, New York, Pennsylvania, Virginia, and Wisconsin) include provisions in their two-way program agreements requiring financial statements or financial reports, with reporting frequencies ranging from monthly to quarterly. Some states also require specific financial information, such as budget-to-actual comparisons (New Mexico, Pennsylvania, and Virginia) or balance sheets for PACE organizations that operate as separate corporate entities (New Mexico).

CMS requires PACE organizations to develop, implement, maintain, and evaluate a quality improvement program (42 CFR 460.130). PACE organizations' quality improvement plans appear as Appendix L in the three-way program agreements and must include objective performance measures related to service utilization, participant and caregiver satisfaction, outcomes, and service effectiveness and safety (42 CFR 460.134). Although CMS requires PACE organizations to internally review these data and use them to improve performance (42 CFR 460.132), federal regulations (42 CFR 460.202(b)) do not clearly specify whether or how PACE organizations must report quality improvement data to CMS or states, stating only that organizations must furnish data "in the manner, and at the time intervals, specified by CMS and the State administering agency." Eight states (California, Massachusetts, Michigan, New York, North Dakota, Ohio, Pennsylvania, and Tennessee) include provisions in their two-way program agreements requiring quality-related reports. For example, California requires an annual summary of quality assurance activities and semiannual progress reports, while Michigan requires an annual report that includes a Quality Assessment and Performance Improvement Plan (QAPIP), QAPIP work plan, and a review of QAPIP effectiveness.

Since 2013, CMS has required PACE organizations to submit Medicare encounter data for services that generate provider claims and, beginning in 2024, to also submit Chart Review Records to capture diagnoses from PACE center services that do not generate claims (CMS 2024e). Seven states (California, Colorado, New York, North Dakota, Ohio, Tennessee, and Wisconsin) also require PACE organizations to submit encounter data directly to the state. Five of these states (Colorado, New York, Ohio,

Tennessee, and Wisconsin) do not specify the scope of required encounter data submissions and instead leave those decisions to state discretion. California and North Dakota, however, further define the scope of required encounter data. California requires PACE organizations to, at a minimum, submit encounter data for all items and services provided to Medicaid enrollees for which the organization is financially liable. North Dakota requires encounter data for services provided to Medicaid enrollees, including examinations, diagnostic and treatment services, supplies, and medical equipment, and specifies that denied claims must be reported when Medicare pays. North Dakota also defines encounters broadly to include physician and professional services, inpatient and outpatient hospital services for which the PACE organization is responsible, prescription drugs, dental care, durable medical equipment, in-home services, and services provided in PACE centers. Although Colorado's two-way program agreement states that PACE organizations shall submit encounter data as directed by the SAA, the state's Department of Health Care Policy and Financing publishes encounter data guidance and allows submission for a wide range of services, including behavioral health, chaplain, home health, therapy, and transportation services (Colorado Department of Health Care Policy & Financing 2021).

Twelve states impose additional reporting requirements beyond those required by CMS. These include service utilization reports (five states: California, Kansas, Massachusetts, New Mexico, and Ohio), fraud and abuse reports (five states: New York, North Dakota, Ohio, Virginia, and Wisconsin), statistical reports (four states: California, Massachusetts, New Mexico, and North Dakota), and provider listings (four states: California, Michigan, Missouri, and Tennessee). Three states (California, Massachusetts, and Michigan) also require demographic data, subcontractor reports, cost reports, and enrollee satisfaction survey results. Other state-specific requirements include Medicare Healthcare Effectiveness Data and Information Set reporting (Tennessee) and day center attendance reporting (North Dakota). North Dakota further requires reporting on additional outcomes, such as risk of nursing facility admission, permanent nursing facility placement, mental health diagnoses, rates of selected infections, and hospital and nursing facility readmissions within 31 days of discharge.

APPENDIX 6B: Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 Section 903 Waiver Requests

Section 903 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554) authorizes the Centers for Medicare & Medicaid Services (CMS) to approve waivers (BIPA 903 waivers) of certain Medicare and Medicaid regulatory requirements for Program of All-Inclusive Care for the Elderly (PACE) organizations. Under this authority, PACE organizations submit waiver requests to the state administering agency (SAA), which reviews the request and either approves or denies it before forwarding approved requests to CMS for final determination. Section 1894 and Section 1934 of the Social Security Act identify five regulatory provisions of the PACE model that cannot be waived:

- serving frail, elderly individuals who require a nursing facility level of care;
- providing comprehensive, integrated acute, and long-term services;
- using an interdisciplinary team;
- using capitated, integrated financing; and
- assuming full financial risk (CMS 2024c).

These requirements define the structural integrity of the PACE model and are treated as non-waivable statutory foundations. In addition, CMS established regulatory flexibilities through a 2019 final rule that reduced certain operational constraints on PACE organizations. These include:

- permitting one individual to fill two separate roles on the interdisciplinary team if the individual has the appropriate qualifications and licenses to fill both roles;
- permitting the required primary care provider role on the interdisciplinary team to be filled by not only physicians but also nurse practitioners, physician assistants, and community-based physicians;
- removing the requirement that interdisciplinary team members primarily serve PACE enrollees; and
- providing greater flexibility on unscheduled reassessments of PACE enrollees (CMS 2019).

Waiver submission and review process. CMS has issued standardized instructions for PACE organizations interested in developing and submitting waiver requests. These instructions specify that applications must include: (1) identification of the submitted document as a waiver request; (2) the specific regulation in 42 CFR 460 to be waived; (3) a rationale for the waiver request; and (4) if applicable, a description of processes to be followed to assure that enrollee care will not be compromised if the request is granted (CMS 2024c).

PACE organizations prepare waiver requests and submit them to the SAA for review. If the SAA does not approve the request, CMS automatically denies it. If the SAA approves the request, it forwards the submission to CMS with any additional comments. CMS then makes a final determination within 90 days of receipt.

Data and methods. To collect more detailed data on BIPA 903 waiver requests, we contacted the 33 states and the District of Columbia that have PACE organizations and requested copies of any waiver requests PACE organizations have submitted to the states, whether they were approved by the state and forwarded to CMS or denied at the state level. We collected waiver requests from nine states (California, Delaware, Massachusetts, Michigan, New York, North Dakota, Pennsylvania, Rhode Island, and Washington). Two additional states (Louisiana and New Jersey) reported that their PACE organizations had submitted waiver requests, but they could not provide copies.

We analyzed 47 waiver requests submitted after the 2019 regulatory changes to ensure comparability under the current flexibilities. We collected information on the submitting PACE organization, state actions, regulatory provisions requested for waiver, and approval outcomes, along with the following additional information: whether the requesting entity was an existing PACE organization or a new PACE applicant; the date of the waiver request; whether the request was new or a resubmission; a description of the requirements being waived, the PACE organization's rationale for waiving these requirements; whether the request was related to the COVID-19 public health emergency; waiver status (granted or denied), if available; date of CMS's final decision, if available; and any applicable comments or notes included in the request. We used additional sources to identify the CMS contract number and PACE organization's website to verify the profit status of the PACE organization (ICRC 2025).

The 47 waiver requests we reviewed were submitted by 32 different PACE organizations. Requests came from PACE organizations in seven states:

- California: 26 requests;
- Pennsylvania: 10 requests;
- Washington: 7 requests; and
- other states (Delaware, Massachusetts, North Dakota, Rhode Island): 1 request each.

California and Pennsylvania account for a disproportionate share of waiver activity, consistent with their larger number of PACE organizations (40 and 18 PACE organizations, respectively) (NPA 2026). Washington state has three PACE organizations, and one of these organizations submitted six waiver requests, more than any other PACE organization.

Types of waiver requests. Waiver requests must indicate the specific sections of 42 CFR 460 that the PACE organization is asking to be waived and the rationale for the request. Table 6B-1 summarizes the waiver requests we reviewed by regulatory section. Nearly all waiver requests clustered around two primary areas: enrollee assessment flexibility and staffing composition requirements.

- **Remote enrollee assessment and service determinations.** Most requests sought waivers of 42 CFR 460.104, which requires in-person enrollee assessments at enrollment, semiannually, and following changes in health status or when the PACE organization expects to deny or partially deny a service determination request. After the COVID-19 public health emergency, many PACE organizations sought to continue using telehealth or telephone-based assessments previously permitted under CMS guidance. PACE organizations offered a variety of rationales for requesting this flexibility, including staffing shortages, efficiency in completing assessments, improved access in

TABLE 6B-1. Program of All-Inclusive Care for the Elderly Federal Regulation Waiver Requests

Section	Number of requests
Enrollee assessments (42 CFR 460.104)	40
Service determination requests (42 CFR 460.121)	17
Interdisciplinary team (42 CFR 460.102)	17
CMS evaluation of PACE application (42 CFR 460.18)	4
Enrollment process (42 CFR 460.152)	2
Plan of care (42 CFR 460.106)	1

Notes: CMS is Centers for Medicare & Medicaid Services. PACE is Program of All-Inclusive Care for the Elderly.

Source: MACPAC, 2026, analysis of PACE organization waiver requests submitted to states and CMS under Section 903 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. 106-554). Requests were collected via outreach to states with PACE programs.

rural areas, and reduced burden for enrollees concerned about COVID-19 transmission reluctant to receive in-person visits. In addition, many PACE organizations said that remote assessments were sufficient to gather needed information about PACE enrollees. Remote assessment also appeared in waiver requests related to service determination processes under 42 CFR 460.121. In these submissions, PACE organizations requested waivers of the requirement that interdisciplinary team members conduct in-person assessments before approving or denying service determinations, instead seeking permission to conduct these assessments virtually. Most requests for waivers of 42 CFR 460.121 also included requests to waive the in-person assessment requirements in 42 CFR 460.104.

- **Master's level social workers.** Many waivers also requested flexibility under 42 CFR 460.102, which governs interdisciplinary team composition and responsibilities. These requests primarily reflected shortages of master's level social workers. Organizations frequently requested permission to substitute other qualified professionals, including licensed professional counselors or bachelor's level social workers.

Not all the waiver requests we reviewed contained information about whether the request was approved or denied. Of the 47 BIPA 903 waiver requests we reviewed, CMS granted 12. Eleven waiver requests were denied at the state level, with 10 of those denials occurring in California and 1 in Pennsylvania. CMS denied four waiver requests that had been previously approved by the SAA, including three from PACE organizations in Washington and one from Rhode Island. The remaining 21 waiver request documents lacked information about whether they had been approved or denied.

Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on May 7, 2026.

Exploring the Role of the State Medicaid Agency in the Program of All-Inclusive Care for the Elderly

6.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to update audit protocols and three-way program agreements to facilitate joint audits of Program of All-Inclusive Care for the Elderly organizations with state administering agencies. Audit coordination should include joint planning of audit scopes, sharing documentation requests, and reviewing evidence concurrently, while preserving CMS's responsibility for assessing federal requirements and states' responsibility for assessing state-specific requirements.

6.1 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
No	0	

6.2 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to aggregate and publicly release, in a user-friendly format on the CMS website, existing Program of All-Inclusive Care for the Elderly (PACE) performance data, including data PACE organizations submit through CMS's Health Plan Management System as well as enrollee satisfaction data collected as part of PACE organization quality improvement programs pursuant to 42 CFR 460.134(a)(2).

6.2 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
No	0	

6.3 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) to amend regulations at 42 CFR 460 Subpart H to develop a standardized, national quality measure set for Program of All-Inclusive Care for the Elderly (PACE) organizations. Quality data should be compiled and made publicly available in an accessible format. CMS should follow three key principles when developing a PACE quality measure set: engage stakeholders collaboratively; minimize reporting burden by focusing on the most meaningful measures; and prioritize standardized measures that enable comparability across programs where feasible.

6.3 voting result	#	Commissioner
Yes	17	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Ingram, Johnson, Karl, Killingsworth, McCarthy, McFadden, Nardone, Snyder
No	0	

Chapter 7:

Provider Enrollment and Credentialing in Medicaid

Provider Enrollment and Credentialing in Medicaid

Key Points

- Medicaid provider enrollment and managed care credentialing aim to ensure that enrollees receive care from qualified providers and protect the program from fraud, waste, and abuse.
- Providers seeking to deliver services to Medicaid enrollees and receive payment from the program generally must enroll with the state. Providers seeking to participate in a managed care network must be credentialed by the managed care plan, in addition to enrolling with the state.
- Federal regulations describe the process that states must follow to enroll Medicaid providers, which includes conducting screenings, checking federal databases, and entering into a provider agreement. States must deny enrollment to providers who do not meet specified requirements; terminate providers for certain violations (e.g., fraud); and revalidate providers at least every five years.
- States have flexibility to determine aspects of the Medicaid provider enrollment process, such as setting additional enrollment requirements, assigning higher risk levels to certain provider types, or requiring additional screening activities. States can also choose to rely on the results of screenings conducted by Medicare or other states.
- The Centers for Medicare & Medicaid Services (CMS) can conduct its own provider screening or implement additional requirements, such as requiring states to check additional databases. CMS can also impose a temporary enrollment freeze for new providers or provider types it identifies as posing a risk to program integrity, unless the state determines that such action would harm enrollee access to care.
- Medicaid provider enrollment and credentialing must be rigorous enough to ensure provider quality and program integrity. However, complex and sometimes duplicative requirements may present compliance challenges for states and deter providers from participating in Medicaid.
- The structure of a state's credentialing system—whether centralized, standardized, or decentralized—can also have implications for the level of effort required of providers.
- The administrative burden of enrollment and credentialing is often most acute for providers in small practices as well as other non-institutional providers (e.g., doulas, community health workers, and school-based health providers) who are newer to the Medicaid program and lack administrative support for these processes. Out-of-state providers may experience additional barriers to Medicaid participation when required to enroll and credential with multiple states and managed care plans.
- Future research could offer additional insight into barriers faced by certain provider types or challenges related to the enrollment and credentialing processes, as well as opportunities to mitigate them.

CHAPTER 7: Provider Enrollment and Credentialing in Medicaid

The primary responsibility of every state Medicaid agency is to facilitate access to covered health services for its enrollees. To make that care available, each state Medicaid agency must engage various types of health care providers, including medical facilities and individual providers as well as other medical service and equipment suppliers, to participate in the Medicaid program.

Medicaid provider enrollment and managed care credentialing processes aim to ensure that Medicaid enrollees receive care from qualified providers. Provider enrollment is the process by which state Medicaid agencies determine whether health care providers who apply to participate in Medicaid are eligible to deliver services to enrollees and receive payment from the program.[1] This process verifies that providers are appropriately licensed according to state law, are not excluded from federally funded health care programs, and are able to meet any other applicable federal and state requirements.[2]

Providers who deliver services and supplies to managed care enrollees must be credentialed to participate in managed care networks.[3] Credentialing is the process by which managed care plans verify that a provider is qualified to deliver care to the plan's enrollees within the scope of their specialty or provider type.[4]

In addition to ensuring the qualifications of Medicaid providers, the provider enrollment and credentialing processes are key mechanisms for preventing the enrollment of providers who have criminal records related to federal health programs or who have engaged in fraud, waste, or abuse (FWA).[5] Although these processes must be rigorous enough to exclude unqualified providers or those who have engaged in misconduct, overly burdensome enrollment and credentialing requirements could deter providers from participating in Medicaid. Recruiting a sufficient number and variety of providers is critical to ensuring that enrollees can access appropriate and timely care.

As part of the Commission's continued focus on access to care for Medicaid enrollees, MACPAC partnered with Acumen, LLC to examine federal and state policies as well as the relevant academic and gray literature pertaining to Medicaid provider enrollment and credentialing. This chapter summarizes the findings from that work. It begins with an overview of federal requirements for provider enrollment and credentialing in Medicaid and a step-by-step overview of those processes.[6] Next, the chapter highlights approaches taken by three states (Ohio, Oregon, and Pennsylvania) as well as challenges for states and providers that emerged from the literature. The chapter concludes by summarizing findings and identifying potential topics for future research. It will be important that any future efforts to identify and mitigate challenges associated with the Medicaid enrollment and credentialing processes are informed by direct engagement with providers, managed care plans, and state and federal officials.

Federal Requirements for Medicaid Provider Enrollment and Credentialing

Medicaid and State Children's Health Insurance Program (CHIP) fee-for-service (FFS) providers as well as managed care network providers are required to enroll with the state Medicaid agency.[7] Federal regulations describe the process that states must follow to enroll providers and have evolved over time as the Medicaid program has grown (Appendix 7A). This process includes steps such as entering into a provider agreement, conducting screening based on perceived risk of FWA, and collecting disclosures of information (CMS 2025a). State Medicaid agencies generally follow Medicare in assigning provider risk levels for provider screening, and states may accept the results of screenings conducted by Medicare and other states. Providers complete enrollment when the state Medicaid agency determines that they have met

all screening requirements and executes an agreement with them (CMS 2016a). The Secretary of the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) oversee parts of the enrollment process and can require or conduct additional screening checks or request information from enrolling providers.

Screening

As part of the enrollment process, state Medicaid agencies must screen providers based on the risk level assigned to their provider type in Medicare (42 CFR 455.410(a), 42 CFR 455.450).[8] The three risk levels (limited, moderate, and high) reflect the perceived risk of FWA posed by each provider type (CMS 2025a). For example, physicians are a limited risk provider type, whereas newly enrolling home health agencies are considered high risk (42 CFR 424.518). Medicare regulations define screening requirements for each risk level. States must set risk levels for provider types either equal to or greater than those set in Medicare and carry out the corresponding required screening activities (42 CFR 424.518).

States must set risk levels for provider types that Medicare does not recognize. These provider types (e.g., non-emergency medical transportation providers) cannot participate in Medicare and therefore do not have a Medicare risk level assigned to them (CMS 2025a). CMS recommends that states assign risk levels to these providers by considering information similar to that used by CMS to assign Medicare risk levels, such as reports from the U.S. Government Accountability Office and U.S. Department of Health and Human Services Office of the Inspector General (OIG), congressional testimony, and input from law enforcement (CMS 2025a). Federal rules require state Medicaid agencies to raise a specific provider's risk level from low or moderate to high in specified situations.[9]

State Medicaid agencies do not always have to conduct the required screening themselves to enroll a provider in their Medicaid program. State Medicaid agencies can rely on screening activities conducted for enrollment in Medicare or another state's Medicaid program or CHIP (42 CFR 455.410(c)). They also can delegate screening activities to managed care plans or other third parties (CMS 2025a). If state Medicaid agencies delegate screening activities, they must ensure that screening is not duplicative for network providers participating with several managed care plans (CMS 2025a).

The state Medicaid agency (or third party, if screening is delegated) must complete the screening activities for providers in each risk level (Table 7-1). The screening activities are cumulative across risk levels, which means that all screening activities from every preceding category must be completed (42 CFR 455.450).

If the state Medicaid agency relies on screening activities conducted for enrollment in Medicare or another state's Medicaid program and the risk level of the provider was lower for the other enrollment process than the state's, the state Medicaid agency must perform the remaining screening activities. For example, if Medicare screened the provider as limited risk but the state considers the provider moderate risk, the state Medicaid agency would need to conduct a site visit as required for moderate-risk providers (CMS 2025a).

Disclosures

Section 1902(a)(78) of the Social Security Act (the Act) requires states to collect basic biographical and practice information from every provider who enrolls in their Medicaid program. This information includes the provider's name, date of birth, Social Security number, specialty, national provider identifier (NPI) (if applicable), federal taxpayer identification number, and state license or certification number (if applicable). These requirements apply to both providers who furnish items and services to enrollees and ordering, referring, and prescribing (ORP) providers (CMS 2025a).[10]

Federal regulations require Medicaid providers to disclose information to the state Medicaid agency about ownership and control, business transactions, affiliations, and relevant criminal convictions. Providers must disclose information about themselves and, when applicable, their managing employees or individuals and organizations with ownership and control interests in the provider. Not all disclosure requirements apply to all providers (e.g., the ownership and control disclosure does not apply to individual providers), and providers must disclose certain information only upon request (42 CFR 455.104–107).

TABLE 7-1. Provider Screening Requirements by Risk Level

Risk level	Screening activity	Description
Limited	☑ **Enrollment eligibility**	Verify that the provider meets federal regulations and state requirements for their provider type
	☑ **License verification**	Confirm the provider has a non-expired license with no limitations that allows them to practice in the state in alignment with applicable state laws
	☑ **Federal database checks**	Confirm the provider's identity and exclusion status by checking the following federal databases: the DEX, DMF, LEIE, NPPES, and SAM[1]
Moderate	☑ **Site visit**	Conduct a site visit to verify the accuracy of information the provider submitted to the state Medicaid agency and check compliance with federal and state enrollment requirements
High	☑ **Criminal background check**	Conduct a criminal background check
	☑ **Fingerprinting**	Require the provider to submit fingerprints

Notes: DEX is the Centers for Medicare & Medicaid Services Data Exchange System. DMF is Death Master File. LEIE is List of Excluded Individuals/Entities. NPPES is National Plan and Provider Enumeration System. SAM is System for Award Management.

DEX allows states to share information on providers who have been terminated from state Medicaid programs and also allows states to access the DMF and view Medicare terminations. The DMF is a database of deceased individuals and their Social Security numbers. LEIE is a database of individuals and entities excluded from participating in federal health care programs. The NPPES is the database of all national provider identifiers, unique numbers assigned to practicing health care providers and organizations. SAM is a database that includes a list of individuals and entities excluded from receiving federal contracts.

[1] States must check DEX at enrollment; the DMF at least quarterly, beginning January 1, 2028; the LEIE at least monthly; the NPPES at an unspecified frequency; and SAM at least monthly.

Sources: 42 CFR 455.412, 455.432, 455.434, 455.436, and 455.450.

Provider agreements

State Medicaid agencies must enter into an agreement with all individuals and organizations that provide services to Medicaid enrollees under the state plan (§ 1902(a)(27) of the Act). As part of the agreement, providers must attest that they will (1) keep records of the services they provide to enrollees, (2) share these records with CMS upon request, (3) comply with federal disclosure requirements, and (4) share their NPI with the state and include it on all claims (42 CFR 431.107(b)).[11] The state Medicaid agency executes the agreement once it has conducted federal and state-specific screening activities and collected applicable disclosures (CMS 2025a, 42 CFR 455.104, 42 CFR 455.106). Provider agreements can be retroactive up to one year (42 CFR 431.108). This allows providers to receive payment for services provided to Medicaid enrollees for a limited period before the provider is enrolled in Medicaid.

Managed care plans must enter into a provider agreement with each provider with whom they contract (42 CFR 438.2). This network provider agreement is distinct from the state Medicaid agency provider agreement. Managed care network providers generally must have agreements with managed care plans and state Medicaid agencies, whereas federal rules require only FFS-only providers to enroll with the state Medicaid agency (CMS 2025a).

Denials

Federal regulations and subregulatory guidance specify circumstances in which state Medicaid agencies must deny the enrollment of providers (mandatory denials) versus when they have the option to do so (discretionary denials). Mandatory denial reasons include but are not limited to failure to submit timely and accurate screening information, failure to comply with screening requirements, criminal conviction related to Medicare or Medicaid within the past decade, and termination from Medicare or the Medicaid program or CHIP of another state (42 CFR 455.416). State Medicaid agencies may exempt a provider from mandatory denial if the denial is "not in the best interests of the Medicaid program," unless the provider was terminated by Medicare or another state's Medicaid program (CMS 2025a, 42 CFR 455.416).[12] Examples of discretionary denial reasons include when the provider submitted false or misleading information, the provider billed with a suspended license or misused their billing number, or the state Medicaid agency cannot confirm the provider's identity (CMS 2025a, 42 CFR 455.416). Regardless of whether the denial is discretionary or mandatory, state Medicaid agencies must inform providers whom they deny enrollment about any state-specific appeal rights (42 CFR 455.422).

Managed care network-only providers

There may be instances in which a state's Medicaid FFS program does not recognize certain types of managed care network providers (e.g., an plan's provider of value-added services, such as nutrition counseling).[13] In these cases, federal rules do not require the provider to enroll with the state Medicaid agency. For example, some managed care plans may include dieticians in their networks. If dieticians are not eligible to enroll in the state's FFS program, CMS does not require them to enroll with the state Medicaid agency to serve managed care enrollees (CMS 2025a). However, CMS recommends that, as a best practice, states require these provider types to enroll with the state as Medicaid providers, such as in an "other" or "managed care-only" provider type category (CMS 2025a). Requiring these providers to enroll subjects them to vetting as part of both enrollment and credentialing processes, including screening by the state Medicaid agency, as opposed to credentialing only. This practice can help protect the program from improper payments by ensuring that the state Medicaid agency screens all providers who receive Medicaid payments, including those who are ineligible to participate in FFS.

Application fee

State Medicaid agencies generally must collect an application fee from enrolling institutional providers (e.g. hospitals, home health agencies) before they execute the provider agreement (42 CFR 455.460). The Medicaid application fee is the same as the Medicare application fee. CMS sets the fee and adjusts it each calendar year according to the Consumer Price Index for all Urban Consumers.[14] CMS can allow states to forgo collecting application fees from certain providers by approving a state's determination that an exception is needed to maintain enrollee access to care (§ 1866(j)(2)(C)(ii).

States collect a provider fee when an institutional provider initially enrolls in the state's Medicaid program, revalidates their enrollment, adds a new practice location, or adds a new owner (CMS 2025a).[15] The application fee subsidizes the cost of required screening activities borne by states and the federal government. Providers who have paid the fee for enrollment in Medicare or another state's Medicaid program or CHIP do not need to pay the fee a second time when enrolling in a state's Medicaid program (CMS 2025a). If the enrollment fees collected by the state exceed the cost of screening, the state must pay the excess fees to the federal government (42 CFR 455.460).

Oversight

CMS has oversight responsibility for state Medicaid agencies' provider screening and enrollment activities and can conduct its own screening or implement additional requirements, as described below:

- **Unannounced site visits.** Enrolled providers must allow CMS or its agents or contractors to perform unannounced site visits of their service locations (42 CFR 455.432).
- **Fingerprint submission.** CMS can ask providers, or any person with at least a 5 percent ownership interest in the provider, to submit fingerprints. The provider must submit fingerprints within 30 days of the request (42 CFR 455.434).
- **Additional database checks.** CMS can require state Medicaid agencies to conduct checks of additional databases beyond those required by federal regulations (42 CFR 455.436(b)).

CMS also provides guidance and technical assistance to states on federal provider enrollment requirements, including by sharing enrollment and screening data and hosting monthly calls to discuss challenges (CMS 2024a). Additionally, CMS can impose a six-month freeze on enrollment of certain providers or provider types it identifies as posing a risk to Medicaid program integrity, though the state Medicaid agency does not have to implement the freeze if it would harm enrollee access to care (42 CFR 455.470(a)). CMS has imposed temporary enrollment freezes on home health agencies in Florida, Illinois, Michigan, and Texas and certain ambulance providers in New Jersey, Pennsylvania, and Texas after determining an increased risk of FWA for these provider types in certain counties (CMS 2018, 2013). Before CMS implemented the enrollment freeze, it confirmed with state Medicaid agencies that doing so would not negatively affect access to care (CMS 2013).

Out-of-state providers

Medicaid enrollees sometimes seek care from providers in a different state, such as when an out-of-state provider is closer than an in-state provider or if providers are not available in their state. For example, for enrollees who live near a state border, a metropolitan area with a hospital that provides specialized services might be closer in a bordering state compared to their own state. States must pay for Medicaid services that its enrollees receive in another state in certain circumstances, such as in an emergency, when the care is more readily available in the other state, or when seeking care in the other state is common practice (42 CFR 431.52).

State Medicaid agencies must enroll providers who render, order, refer, or prescribe care to their enrollees, which generally includes out-of-state providers (§ 1902(a)(78) of the Act). States can reimburse for Medicaid services rendered, ordered, or referred by a non-enrolled out-of-state provider when specific criteria are met—for example, if a provider is enrolled in Medicare or another state's Medicaid program. Out-of-state providers who do not meet these criteria must enroll in the state Medicaid program that is paying for the care.

Federal policymakers have considered opportunities to minimize the effect of provider enrollment requirements on timely access to out-of-state care for children with complex health care needs who often need specialized care that is available from a limited number of centers of excellence (e.g., children's hospitals) nationwide. In response to a congressional directive, CMS issued guidance in 2021 recommending that states shorten the enrollment and screening time frame for out-of-state providers for children with medically complex conditions, including by relying on screenings conducted by Medicare and other state Medicaid programs. CMS notes that states may also be able to use information collected by another state, such as federally required disclosures, to streamline enrollment for out-of-state providers (CMS 2021).[16] In separate guidance on best practices for adhering to early and periodic screening, diagnostic, and treatment (EPSDT) requirements, CMS further recommends that states streamline the provider enrollment and screening process to reduce administrative burden for providers who treat children and youth (CMS 2024b).

Indian Health Care Providers

Indian Health Care Providers (IHCPs) operating through the Indian Health Service must enroll in Medicaid to receive payment for services delivered to American Indian and Alaska Native (AI/AN) Medicaid enrollees. States may not impose additional eligibility requirements on IHCPs seeking to participate in Medicaid. Federal regulations also bar states from requiring that IHCPs enrolling in Medicaid possess a state license, so long as the IHCP meets all applicable licensure requirements (42 CFR 431.110). Managed care plans must pay IHCPs for any covered services delivered to the plan's AI/AN enrollees, even if the IHCP does not participate in the managed care network or is not enrolled in Medicaid (42 CFR 438.14).

Maintaining provider enrollment

Several federal requirements aim to ensure enrolled providers continue to meet the standards the state Medicaid agency evaluated during the initial enrollment process. This includes processes to periodically revalidate and, if necessary, terminate enrollment.

Revalidation

State Medicaid agencies must revalidate a provider's enrollment at least once every five years (42 CFR 455.414). The revalidation process is similar to the initial enrollment process in that providers must submit a revalidation application, and the state Medicaid agency must complete the full screening process according to the provider's assigned risk level (CMS 2025a). Similar to initial enrollment, state Medicaid agencies can rely on screening results for revalidation in Medicare or another state's Medicaid agency. Providers do not need to submit a revalidation application if the provider has been revalidated in Medicare (CMS 2025a).

In April 2026, CMS sent a letter to state Medicaid directors requesting that they submit a two-year provider revalidation strategy and notify the agency of their plans to swiftly revalidate high-risk providers.[17] CMS requested that state provider revalidation plans prioritize a comprehensive review and revalidation of Medicaid providers and describe how states enroll providers without NPIs. CMS further encouraged states to increase oversight of providers who pose a high risk of FWA by revalidating their enrollment more frequently than once every five years as required by federal rules (CMS 2026a). CMS sent a separate letter to governors reiterating the agency's request that states quickly revalidate high-risk Medicaid providers (CMS 2026b).

Termination

State Medicaid agencies must terminate a provider's agreement "for cause" for specific reasons.[18] Causes for mandatory termination closely mirror the circumstances in which states are required to deny enrollment, such as failure to submit timely and accurate information, criminal convictions related to federal health care programs in the past 10 years, and failure to comply with screening requirements (CMS 2025a).

Similar to enrollment denials, state Medicaid agencies have the discretion to terminate provider agreements for cause for additional reasons that include but are not limited to abuse of billing privileges, billing with a suspended license, improper prescribing practices, and previous patient harm (CMS 2025a).

State Medicaid agencies must report providers whom they terminated for cause to CMS (42 CFR 455.417).[19] The CMS Data Exchange System is the database of terminated providers (including providers terminated from Medicare) and the platform for reporting them. Providers remain in the termination database for the lesser of 10 years or the duration specified by the state that initially terminated them (42 CFR 455.117(a)). Terminated providers cannot reenroll while they are in the termination database, and other state Medicaid programs must terminate or deny their enrollment during this time (42 CFR 455.416-17).

Provider credentialing

Provider credentialing is a component of a managed care plan's selection of network providers designed to ensure that such providers are qualified to care for Medicaid enrollees (42 CFR 438.214).[20] Federal regulations set forth requirements for provider credentialing as part of a broad set of policies to improve the quality of managed care at a time when managed care network providers were not yet required to enroll with the state (67 FR 40989). States must develop credentialing policies for their managed care plans based on parameters described

in federal regulations, which are less specific than federal enrollment and screening requirements (42 CFR 438.214) (Table 7-2). Federal credentialing requirements apply only to managed care network providers and not to providers who participate in FFS only.

State flexibilities

Federal requirements represent the minimum activities state Medicaid agencies must complete to enroll and screen providers and to establish policies for managed care credentialing of network providers. States have the flexibility to implement additional screening requirements (42 CFR 455.452). Examples of ways states can leverage this flexibility include the following:

- requiring more frequent revalidation (i.e., more frequently than every five years);
- checking databases not required by federal regulations, such as the Provider Enrollment, Chain, and Ownership System (PECOS) and state-specific databases (e.g., lists of providers excluded from the state's Medicaid program);[21]
- requiring providers to obtain professional liability insurance;
- implementing risk levels and screening requirements that are stricter than Medicare's; and
- requiring moderate- and high-risk provider types recognized by Medicare (e.g. ambulance service suppliers, home health agencies) to enroll in and be screened by Medicare (CMS 2025a, Division of TennCare 2022).

States also have the flexibility to set "reasonable" standards for Medicaid provider qualifications (42 CFR 431.51(c)(2)). These state-specific standards may influence decisions regarding provider enrollment denial and termination decisions (CMS 2025a). For example, states may require additional credentials or certifications to enroll as a certain provider type, and states may deny enrollment to providers who fail to meet these standards.[22]

Additionally, under Section 1135 of the Act, CMS can temporarily waive federal provider enrollment and screening requirements to help states respond to public health emergencies (PHEs) by, for example, making it easier for providers to care for Medicaid enrollees in states where they were not previously enrolled in Medicaid (MACPAC 2020b) (Box 7-1). In cases when both the president has declared a disaster or emergency and the HHS Secretary has declared a PHE, states can request to temporarily waive certain federal Medicaid requirements through Section 1135 waivers (MACPAC 2020b; § 1135 of the Act). CMS may issue waivers in response to state requests or may issue blanket waivers that apply to all providers in an affected area (MACPAC 2020b).

TABLE 7-2. Federal Requirements for Provider Credentialing

Topic	Requirement
Uniform credentialing	Each state must establish a uniform policy for credentialing and recredentialing providers. In this context, "uniform" means that states must develop and apply these policies in a consistent way that engenders equitable outcomes, prevents discrimination, and allows managed care plans to create networks that fulfill their enrollees' needs. States set the foundation of credentialing and recredentialing requirements that managed care plans must follow and can allow plans to establish the specifics of their policies.
Documented process	Managed care plans are required to document their credentialing and recredentialing processes. These processes are typically documented in managed care provider manuals.

Notes: Managed care plans are managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, as defined in 42 CFR 438.2.

Sources: 42 CFR 438.214, CMS 2016a.

Overview of the Provider Enrollment and Credentialing Processes

This section describes how states and managed care organizations operationalize the provider enrollment and credentialing processes.

Provider enrollment process

Although the Medicaid provider enrollment process is complex and varies by state, it generally consists of the steps described below and further detailed in Figure 7-1.

Step 1: Provider applies for enrollment

A provider applies for Medicaid participation. In the application, providers submit requested information about their licensure and professional certifications as well as applicable disclosures regarding ownership and control, business transactions, criminal convictions, and affiliations. The documentation requested by the state may vary by provider type. Some provider types must also pay an application fee.

Step 2: State reviews application

The state must review whether the provider meets state and federal requirements for participation in Medicaid. This includes reviewing the provider's licensure and certification and proof of insurance as well as confirming the provider has paid any required enrollment fees. States may request additional information or revisions to the application.

Step 3: State completes screening

The state must complete a risk-based screening process for the provider based on their provider type. For provider types that are recognized by Medicare, states must assign a risk level that is the same as or higher than the Medicare risk level defined in federal regulations (42 CFR 424.518). States can describe risk levels in state statute or publish them online.

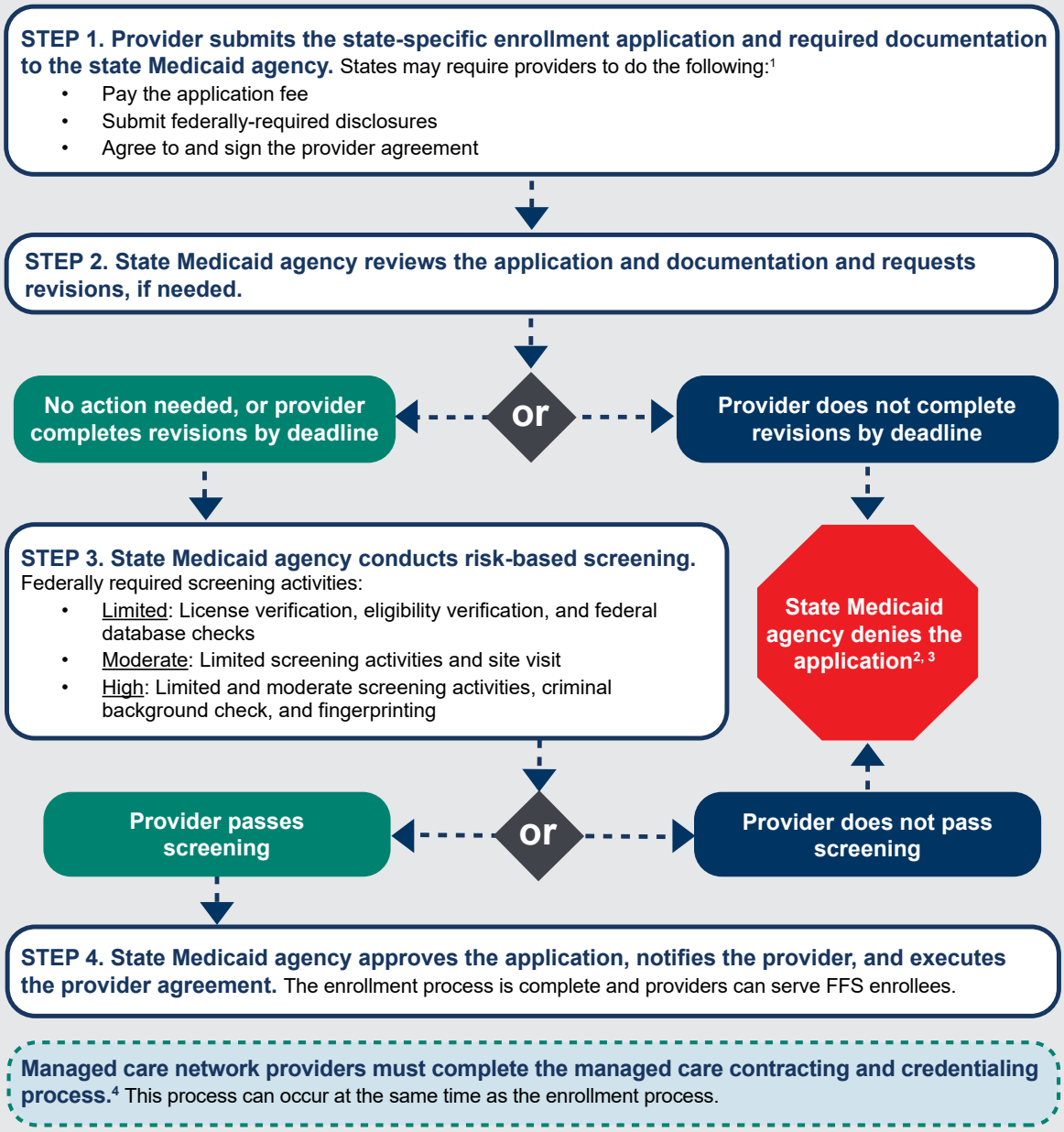
Step 4: State executes provider agreement

The enrollment process is complete when the state Medicaid agency executes an agreement with the provider. Although the provider may submit a signed provider agreement during the initial application submission in step 1, the execution of the agreement occurs at the end of the enrollment process when providers can begin receiving Medicaid payment for covered services delivered to enrollees. A provider must revalidate their enrollment with the state regularly (CMS 2025a).

BOX 7-1. Section 1135 Waivers during the COVID-19 Public Health Emergency

Section 1135 of the Act allows the Secretary of the U.S. Department of Health and Human Services to waive or modify numerous federal Medicaid requirements during an emergency, including certain conditions of provider participation. During the COVID-19 public health emergency (PHE), all 50 states and the District of Columbia had approved Section 1135 waivers to facilitate provider participation in Medicaid and address anticipated workforce shortages, though states' use of these flexibilities varied and was not documented on a national level (Manetto et al. 2020). The approved waivers allowed states to provisionally enroll providers who were enrolled with Medicare or another state Medicaid agency for the duration of the PHE. For providers not already enrolled in Medicare or another state's Medicaid program, states were permitted to waive certain screening requirements, including payment of application fees, criminal background checks, site visits, and licensure requirements, to help with enrollment. States were also permitted to temporarily halt provider revalidation. The Centers for Medicare & Medicaid Services generally expected provider revalidation to resume at the end of the PHE. States were required to screen and enroll providers who had been provisionally enrolled or otherwise terminate them from their Medicaid programs within six months of the end of the PHE (CMS 2025c).

FIGURE 7-1. Medicaid Provider Enrollment Process



Notes: FFS is fee for service. Managed care refers to managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, as defined in 42 CFR 438.2.

[1] The enrollment application is a common vehicle for meeting these requirements, but states may choose to meet these requirements at a different part of the process.

[2] The state Medicaid agency must notify providers denied enrollment of any state-specific rights to appeal the decision (42 CFR 455.422).

[3] Per 42 CFR 455.416(d), providers denied enrollment due to failure to submit information in a timely manner must restart the enrollment process from step 1.

[4] Being enrolled with the state Medicaid agency does not require managed care-only providers to serve fee-for-service enrollees (42 CFR 438.602(b)(1)).

Sources: 42 CFR 431.107, 438.602(b)(1), 455.104–107, 455.410, 455.422, 455.450, and 455.460.

The managed care credentialing process may occur either during or after the enrollment process, depending on state rules and regulations. Some managed care credentialing processes may require outputs of the enrollment process (e.g., a state provider ID), which requires the provider to complete the state agency enrollment process first.

Managed care credentialing process

Federal regulations require that states establish their own credentialing policies, and thus, they vary in how they carry out the credentialing and recredentialing processes (42 CFR 438.214(b)(1)). Credentialing includes activities such as verifying a provider's license, education, practice history, and any sanctions from state agencies or licensing boards (CMS 2025a, OIG 2013). The details of this process depend, in part, on the organization of each state's credentialing system. Some states have a centralized credentialing process, in which providers can complete a single application to credential with multiple managed care plans. Other states have a standardized process, in which providers submit a separate application with standardized information to each managed care plan with which they wish to participate. Other states have a decentralized credentialing process, in which providers submit plan-specific credentialing applications to each managed care plan.

The state's chosen approach to credentialing affects the experience of providers by, among other things, determining whether providers send materials to the state Medicaid agency or managed care plan, how many applications they need to submit to participate with multiple managed care plans, and whether they must submit different information and documentation to become credentialed by different managed care plans. State requirements for managed care plans to receive accreditation by the National Committee for Quality Assurance (NCQA) can also affect credentialing requirements and provider experience.[23] Despite state variation, the credentialing process generally consists of a few key steps, which are detailed below and in Figure 7-2.

Step 1: Provider applies for credentialing

A provider applies for participation with an managed care plan. This involves submitting a credentialing application and any supporting documentation required by the state or managed care plan. Credentialing is part of the overall contracting process.

Step 2: Credentialing entity reviews application

The credentialing entity reviews a provider's application. The credentialing entity might be the state Medicaid agency, the managed care plan, or a contractor.

Step 3: Credentialing entity verifies information

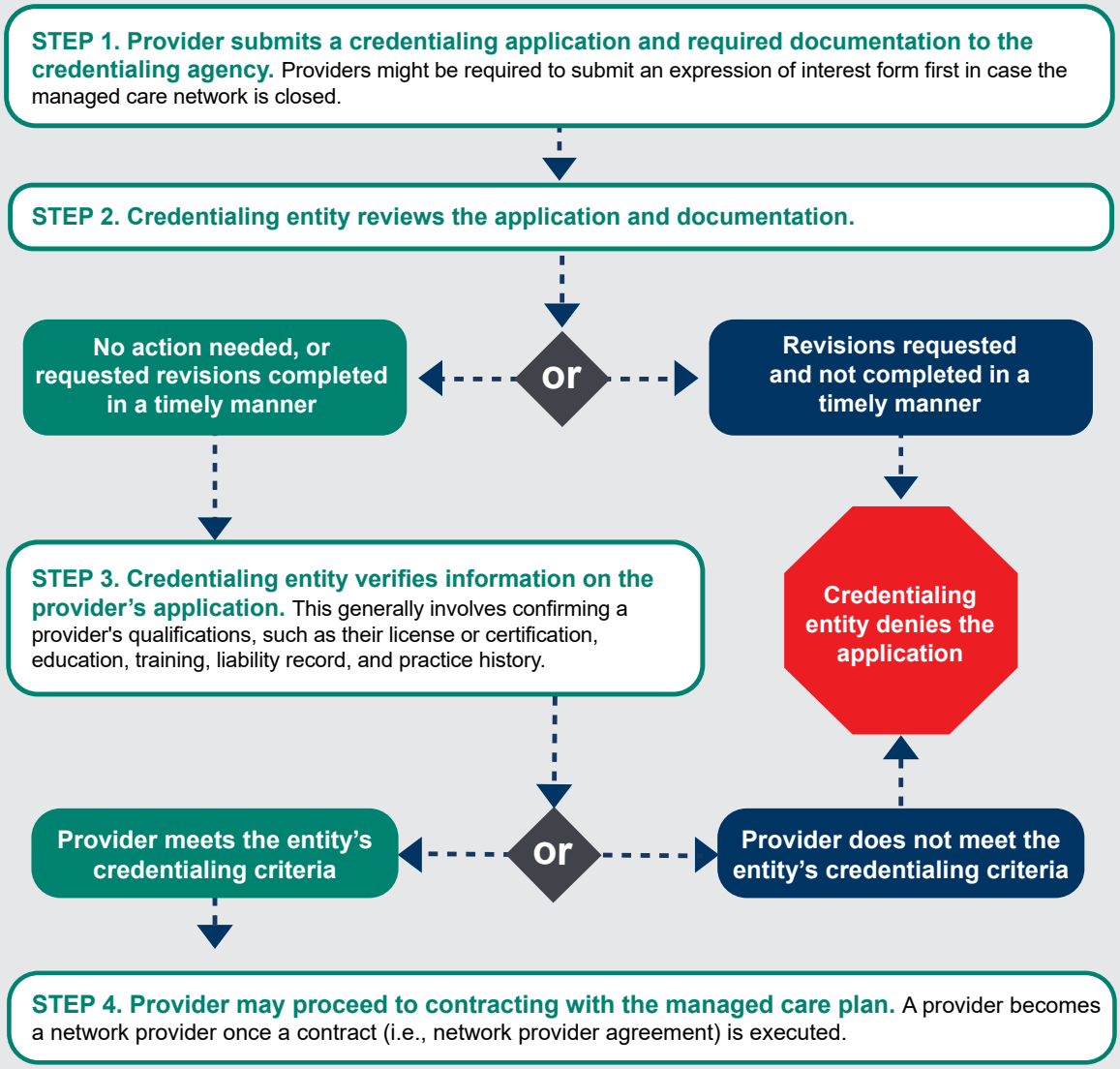
The credentialing entity verifies the accuracy of the information and documentation provided in the credentialing application. This review process may involve activities such as verifying a provider's license, education, practice history, and any sanctions from state agencies or licensing boards (CMS 2025a, OIG 2013).

Step 4: Credentialing requirements are met

Providers who meet the credentialing criteria and any additional requirements set by the state or managed care plan may contract with the managed care plan. The provider becomes a network provider once the managed care plan executes the contract (i.e., the network provider agreement).

As described earlier, whether providers can concurrently complete the enrollment and credentialing processes varies by state and by managed care plan (for states without centralized credentialing). Under federal law, managed care plans can execute network provider agreements before providers complete the screening and enrollment process but must terminate the agreement if the state denies the provider's application or 120 days have passed and the state has not executed the provider agreement (42 CFR 438.602(b)(2)).

FIGURE 7-2. Medicaid Managed Care Provider Credentialing Process



Note: Managed care plans are managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, as defined in 42 CFR 438.2.

Source: CMS 2025a.

Provider Enrollment and Credentialing in Three States

Although federal regulation sets certain requirements for enrollment and credentialing, states may implement and operationalize these requirements in different ways. This section discusses how three states—Ohio, Oregon, and Pennsylvania—implement the provider enrollment and credentialing processes, based on review of state laws and publicly available information as well as resources from state Medicaid agency websites, provider portals, and managed care plans. In selecting these states for analysis, MACPAC considered factors such as the structure of their credentialing systems, the number of managed care plans operating within the state, and the presence of large population centers along their borders, which may increase the need for enrollees to seek care across state lines.

Provider enrollment process

Ohio, Oregon, and Pennsylvania have used the flexibilities granted to them by Medicaid statute and regulations to establish provider enrollment processes that vary in some ways. There are differences, for instance, in their screening and documentation requirements, their treatment of certain provider types (e.g., out-of-state providers), and their use of additional databases as part of the screening process.

Initial application

States determine what information to collect in the provider's initial application. Ohio, Oregon, and Pennsylvania require different forms and documentation based on provider type. In each state's online applications, the form displays components relevant to the provider type selected. For example, Ohio's online application guides providers through a series of pages and questions based on their selected provider type (ODM 2022a). Similarly, the state requires different providers to submit specific credentials or licensure proof. Pennsylvania's Medicaid agency website includes a list of provider types and outlines required documentation for each type. For instance, among other documents, physician assistants must provide a document from Pennsylvania's Department of State that verifies their licensure and lists the physicians they will work with, which must be signed by those physicians (Pennsylvania DHS 2025a). Each of the three states also collects applicable disclosures as part of the initial application.

ORP and managed care network-only providers

States may have different enrollment applications for ORP providers and managed care network-only providers. In Ohio and Oregon, ORP providers enroll as a specific provider type (e.g., as a non-payable provider in Oregon) (OHA 2025a, ODM 2022a). In contrast, Pennsylvania requires that ORP providers enroll according to their provider type (e.g., psychiatrist or physician assistant) (Pennsylvania DHS 2022a, 2016a). Similarly, states may have different enrollment requirements for managed care network-only providers. In Ohio, network-only providers (and all other providers) complete enrollment and credentialing through a single online application hosted by the state (ODM 2025a). In Oregon, network-only providers enroll as "non-payable" providers. Pennsylvania does not appear to have an application specific to network-only providers, based on a review of publicly available documents (Pennsylvania DHS 2025a).[24]

Out-of-state providers

Ohio, Oregon, and Pennsylvania require out-of-state providers to enroll in their Medicaid programs to receive payment for services rendered to their Medicaid enrollees. Pennsylvania further requires that out-of-state providers be enrolled in their home state's Medicaid program.[25] The three states also require out-of-state providers to be licensed or certified by their home state.[26]

Oregon requires some out-of-state providers (e.g., certain telehealth and behavioral health providers) to have an Oregon license (OHA 2024a). For these out-of-state providers or providers relocating to Oregon from another state, the process to get an Oregon license may be complicated because Oregon does not participate in the Interstate Medical Licensure Compact (IMLC) (OMB 2025). Although states have their own medical licensing processes, the IMLC eases the burden of medical licensing for physicians who practice in multiple states by allowing eligible physicians to complete one application to become

licensed in any state that participates in the compact (IMLC 2021). Thus, in Oregon, physicians who need an Oregon license to enroll in Medicaid must go through the state's licensing process. To streamline the process, the state implemented expedited endorsement, which allows physicians with a current license in another state to enroll without the state verifying their core credentials with the credentialing body (OMB 2025).

Retroactive enrollment

All three states permit retroactive enrollment, which permits the effective date of a provider's enrollment to precede the date of the application submission. This allows providers to submit claims and receive payment for services that they provided to Medicaid enrollees for a period before the provider was enrolled in Medicaid. In Ohio and Oregon, providers can enroll retroactively for up to a year, the maximum period allowed under federal law (ODM 2025a, PacificSource Community Solutions 2024, 42 CFR 431.108). In Pennsylvania, enrolling providers must submit documentation explaining why they are requesting retroactive enrollment beyond 30 days before the application submission (Pennsylvania DHS 2022b).[27]

Defining risk levels

Once providers submit an enrollment application, states assign a risk level to the applying provider based on their provider type and carry out the appropriate screening activities according to state and federal law. Ohio, Oregon, and Pennsylvania generally use the Medicare risk levels for Medicaid providers. For provider types not in Medicare, Pennsylvania publishes a list of provider types associated with moderate- and high-screening risk levels; the state considers non-Medicare provider types not on that list as limited risk (Pennsylvania DHS 2016b). Similarly, Ohio categorizes a few non-Medicare provider types as high risk, including supplemental transportation and wheelchair vans.[28] Oregon's administrative rules do not provide clear guidance on risk levels for provider types that do not enroll in Medicare (OHA 2021).[29]

Screening

States have options for alleviating some of the administrative burden of screening providers, including relying on screening activities conducted by another entity or delegating screening activities to a third party. Oregon and Pennsylvania use screenings conducted by Medicare, and Pennsylvania uses screenings conducted by other states' Medicaid programs and CHIP, so that providers enrolled in those programs do not have to undergo additional screening (OHA 2025b, Pennsylvania DHS 2024a). States may also subcontract parts of the screening process; both Ohio and Pennsylvania contract with private firms to conduct provider site visits (Ohio Council 2023, Pennsylvania DHS 2016b).

States may perform database checks beyond those required by federal regulations. For example, Ohio state code lists federal databases and state-specific registries (e.g., an abuser registry maintained by the Ohio Department of Developmental Disabilities) that the state Medicaid agency must check. Pennsylvania requires checks of PECOS as well as its own list of providers excluded from participating in the state's Medicaid program (Pennsylvania DHS 2017). All three states maintain such lists, though Ohio and Oregon do not require the state Medicaid agency to check them during the provider screening process, according to a review of publicly available sources.[30] A description of databases that states may check as part of the provider screening process, as well as those that are federally required, is included in Table 7B-1 in Appendix 7B.

Approval and revalidation

After the state completes screening activities and approves the provider's application, the state executes the provider agreement, and the provider becomes enrolled in Medicaid. No federal regulations dictate how long states should take to enroll providers. Ohio, Oregon, and Pennsylvania do not provide a timeline for reviewing provider enrollment applications, while Pennsylvania estimates 30 days for processing revalidation applications. Ohio notes that the timeline depends on the number of provider applications it has received (ODM 2022a). For providers denied enrollment, each of the three states has an appeals process. For example, in Oregon, providers must submit an appeal to the Oregon Health Authority's Health Systems Division in writing within 180 days that includes the reason the provider disagrees with the denial decision.[31]

After initial enrollment, providers must periodically revalidate their enrollment. Ohio, Oregon, and Pennsylvania require that providers revalidate their enrollment at least as often as every five years, the minimum frequency required under federal law. However, Ohio requires some providers to revalidate every three years to align with the recredentialing process (i.e., credentialing renewal) to reduce administrative burden (ODM 2025c). The materials and documentation required for revalidation vary by state. Ohio requires most providers to only update their existing information (ODM 2022b). By contrast, providers in Oregon must resubmit a completed enrollment form and provider agreement, and providers in Pennsylvania must resubmit a completed enrollment application (OHA 2025c; Pennsylvania DHS 2024a, 2016c).

Managed care credentialing process

Ohio, Oregon, and Pennsylvania take different approaches to managed care provider credentialing. This section details the credentialing and recredentialing processes for Medicaid managed care providers in each of the three states.

Centralized credentialing

Centralized credentialing allows providers to credential with multiple managed care plans through a single credentialing application. Relative to decentralized and standardized credentialing, centralized credentialing is the least administratively burdensome method of credentialing in states with multiple managed care plans, as providers submit only one application, removing the need to undergo separate credentialing processes with multiple plans.

Ohio uses a centralized credentialing process wherein providers submit a single enrollment and credentialing application. In Ohio, providers must complete the enrollment process before credentialing (ODM 2022c). The state contracts with an NCQA-certified credentials verification organization to complete certain credentialing tasks, such as monitoring for provider sanctions and collecting primary source verifications like licensure or Drug Enforcement Administration (DEA) certificates (ODM 2025b). The state has assembled a credentialing committee that oversees the credentialing program and approves or denies provider credentialing applications (ODM 2023).

Standardized credentialing

Standardized credentialing systems require providers to submit separate credentialing applications to each managed care plan they wish to participate in and require all plans to follow the same application process. In standardized systems, providers submit the same form and documentation for each managed care plan, removing the need to fill out multiple plan-specific credentialing forms. Relative to centralized credentialing, standardized credentialing may be more time consuming for providers, who need to submit separate applications to each plan they want to contract with.

Oregon requires all coordinated care organizations (CCOs) (the term used for managed care plan in Oregon) to use a standardized credentialing form.[32] The form has fields for providers to input a variety of information, including sections for board and other certifications; practice and employment information; educational history; health care license, registration, and certificate numbers; hospital and health care facility affiliations; professional practice and work history; peer references; and continuing medical education.[33] Along with the completed standardized credentialing form, Oregon requires providers to submit copies of their license, DEA or controlled substance registration certificate, Educational Commission for Foreign Medical Graduates certification (if applicable), and documentation of a professional liability policy or certificate (OHA 2024b).

Decentralized credentialing

In decentralized credentialing systems, providers must complete separate credentialing processes with each managed care plan; these processes and the required forms and supporting documentation may differ by plan. Compared to centralized credentialing (as in Ohio) and standardized credentialing (as in Oregon), decentralized credentialing may require more time and effort on the part of providers, particularly those seeking to contract with multiple plans.

Pennsylvania has decentralized credentialing and relies on managed care plans to conduct credentialing. Providers in Pennsylvania can begin the managed care credentialing process before they enroll with the state, though to complete the process, they must have a Medicaid identification number, which the state issues once the provider is enrolled (Pennsylvania

DHS 2024b). Pennsylvania requires managed care plans to complete the credentialing process within 60 calendar days of receiving a completed application (Pennsylvania DHS 2025b). If a plan denies a provider's credentialing application, they must share the rationale for the decision with the provider (Pennsylvania DHS 2024b).

Pennsylvania has defined the type of information that managed care plans must verify (such as licensure and malpractice coverage) when credentialing providers (Pennsylvania DHS 2024b). Some health plans in the state rely on the Council for Affordable Quality Healthcare and other vendors to complete the credentialing process.[34] Some have a credentialing committee to help make credentialing decisions; for one large insurer, this committee is national and covers all of the carrier's health plans (UnitedHealthcare 2025). Managed care plans must submit a monthly report to the Pennsylvania Department of Human Services with details about applications received, under review, or decided within the month. Plans submit similar information every two years to the Pennsylvania Insurance Department, in addition to information about providers terminated from the plan for "reasons of quality."[35]

Recredentialing

Providers must recredential (i.e., renew their credentialing) regularly. There is no federally required timeline for recredentialing (42 CFR 438.214). However, Ohio, Oregon, and Pennsylvania all require recredentialing every three years. This process generally involves verifying that a provider's data, licensure or certification, and personal information is correct and up to date. As with the initial credentialing process, the type of information required of providers and the process for submitting it (e.g., to the state or to managed care plans) varies.

Medicaid Enrollment for Select Provider Types

Some providers who are newer to Medicaid or who practice in non-medical or non-institutional settings may be particularly affected by the complexities of the Medicaid provider enrollment and credentialing because they have less experience and familiarity with these processes compared to traditional medical providers. Moreover, some states require them to take additional steps to enroll or credential. This section discusses the enrollment and credentialing processes for four such provider types—school-based services providers, doulas, community health workers (CHWs), and peer support specialists—in Ohio, Oregon, and Pennsylvania.

School-based services providers

School-based services are Medicaid-covered services provided in schools by personnel who are employed by or contracted with a school or local education agency (LEA). Most states cover school-based services for students with disabilities pursuant to an individualized education program (IEP) or an individualized family service plan (IFSP), though most states do not require their LEAs to bill Medicaid for those services (ED 2024).[36] As of 2023, 25 states cover school-based services for students without an IEP/IFSP.[37] Like most states, Ohio, Oregon, and Pennsylvania provide school-based services through FFS delivery systems and carve these services out of managed care contracts (HSC 2023b). In each of the three states, LEAs enroll as Medicaid providers, and, because they do not contract with managed care plans, credentialing requirements do not apply.

In addition to the LEAs, individual school-based services providers must enroll in Medicaid if they order or render reimbursable services to Medicaid enrollees and if the state recognizes them as Medicaid providers.[38] Non-school-based providers who order or refer Medicaid services to be performed by a school-based services provider must also enroll, in accordance with federal requirements. Each of the three states provides specific support and training materials for enrolling these school-based services providers. Oregon, for instance, provides an enrollment guide, frequently asked questions, and videos to support school-based services providers through the Medicaid provider enrollment process (OHA 2025d). Ohio and Oregon also help with the enrollment of LEAs by allowing them to apply via an electronic portal, whereas Pennsylvania required paper applications until March 2025.

Ohio, Oregon, and Pennsylvania delegate to LEAs some responsibility for screening school-based services providers. In Ohio, LEAs are responsible for ensuring that employees or contractors who provide Medicaid services undergo and successfully complete criminal background checks according to Ohio state code.[39] In Oregon, LEAs must document the credentials and qualifications of their medical staff and the manner in which the LEA checked and periodically rechecked the HHS OIG's Medicaid provider exclusion list to confirm staff are eligible to provide Medicaid services.[40] In Pennsylvania, LEAs must screen employees and contractors providing Medicaid services to check for exclusion from federal health care programs (Pennsylvania DHS 2024c).

School-based services providers can face confusion and unclear state guidance regarding which providers must enroll in Medicaid and the process for enrolling. Federal regulations require rendering and ORP providers to enroll in Medicaid, even if they are not submitting claims to Medicaid (42 CFR 455.410). Although this requirement is not new, recent CMS guidance clarified that this requirement applies to school-based services providers, including those whose LEAs submit claims for the services they render (CMS 2023). This clarification, and the recent expansion of school-based Medicaid to students without an IEP/IFSP in many states, has introduced additional perceived administrative burden for school-based services providers who must enroll.[41]

School-based services providers may experience difficulty enrolling if they are not traditional health care providers who have previously enrolled in Medicaid. Schools are not traditional health care settings and may not have the institutional knowledge and resources available to guide providers through the enrollment process. Guidance from states can therefore be a key resource for school-based services providers to clarify who must enroll and the process for doing so. Oregon states that supervisory-level recognized providers who work for or contract with an LEA must enroll as a Medicaid provider (OHA 2025e). Similarly, Pennsylvania guidance specifically notes that all physicians and other practitioners who order and prescribe school-based services must enroll in Medicaid (Pennsylvania DHS 2024c). In Ohio, the published guidance available online is unclear about the need for ORP or rendering school-based services providers to enroll in Medicaid.

Doulas

Doulas are trained professionals who provide guidance and support to women and families before, during, and after childbirth. As of 2022, 27 state Medicaid programs covered doula services, and 9 were in the process of implementing coverage (Chen 2022). Coverage of doula services is relatively new for many state Medicaid programs. As a result, doulas may lack prior experience becoming an enrolled Medicaid provider and the institutional and administrative support to navigate and complete the enrollment and credentialing process with ease. Furthermore, because doulas historically provided services to their clients on an individual basis as independent contractors, they may be unaccustomed to working with health plans and unfamiliar with Medicaid billing practices (Chen 2022).

Ohio, Oregon, and Pennsylvania allow doulas to enroll as Medicaid providers and bill the program directly (OHA 2025f, ODM 2024a, Pennsylvania DHS 2024d). Each state permits doulas to enroll as Medicaid providers if they meet state-specific doula certification requirements. Doulas in Ohio must be certified by the state board of nursing (either through a certifying organization or experience), and doulas in Oregon must have a traditional health worker certification (OHA 2025f, ODM 2024a). In Pennsylvania, doulas must be certified as a perinatal doula from the Pennsylvania Certification Board (Pennsylvania DHS 2024d).

Both Ohio and Pennsylvania provide specific resources for doulas to navigate the enrollment process. For example, Pennsylvania provides a training video, slide deck, and enrollment frequently asked questions page for doulas (Pennsylvania DHS 2025c, Pennsylvania DHS 2024e). Oregon provides a billing guide for doulas with some enrollment instructions as well as online guidance on becoming a certified doula (OHA 2025f).

CHWs

CHWs are public health workers who connect individuals in their communities to health and social services (APHA 2025). CHWs typically share socioeconomic and cultural backgrounds with their clients and may also share other lived experiences, including similar health conditions and social needs. Some of these experiences, such as prior struggles with substance use disorder (SUD) or involvement with the criminal justice system, may present barriers to enrollment as a Medicaid provider (MACPAC 2022). CMS requires that CHW services provided as a preventive service be recommended by a licensed provider; the services must be either ordered or supervised by a licensed provider, depending on the regulatory authority through which the states provide CHW services (D'Alessandro et al. 2024, 42 CFR 440.130, 42 CFR 440.60). As of 2022, 29 states allowed Medicaid payment for services delivered by CHWs (Haldar and Hinton 2023).

Ohio, Oregon, and Pennsylvania have different rules regarding whether CHWs can enroll in and directly bill Medicaid and whether they need supervision. In Ohio, CHWs do not enroll in Medicaid, but managed care organizations (MCOs) must provide CHW services by contracting either directly with CHWs or with agencies employing them (NASHP 2025a). In Oregon, CHWs enroll as a non-payable provider type, since they are a rendering provider that must work and bill under the supervision of a licensed provider. The state's CHW billing guide provides instructions on how they should enroll in Medicaid (OHA 2024c). In Pennsylvania, CHWs cannot enroll in Medicaid, but the state requires MCOs to provide CHW services (NASHP 2025b).

Peer support specialists

Peer support specialists, who are individuals with lived experience of a mental health or SUD condition, help individuals engage with and stay in behavioral health care. These providers perform various services, such as connecting enrollees to resources and helping them navigate care systems, in a variety of settings (e.g., community organizations, outpatient centers, carceral facilities, emergency rooms) (SAMHSA 2024). As of 2022, 39 states and the District of Columbia covered Medicaid peer support services (KFF 2022). Federal regulations require Medicaid peer support specialists to have completed some form of training and certification, though states set the minimum training and certification requirements for these providers to participate (CMS 2024d).

Ohio, Oregon, and Pennsylvania cover peer support specialists and have related certification pathways but have different policies on their enrollment as Medicaid providers. In Ohio, peer support specialists cannot enroll. Instead, enrolled community behavioral health agencies list their affiliated certified peer support specialists and bill for their services (ODM 2024b). In Oregon, peer support specialists enroll in Medicaid as non-payable providers and other enrolled organizations (e.g., primary care clinics and behavioral health organizations) bill for their services (OHA 2025h). Oregon provides a billing guide for peer support specialists, which includes instructions on how to enroll in Medicaid.[42] Finally, in Pennsylvania, peer support specialist agencies enroll in Medicaid and bill for their staffs' services (Pennsylvania DHS 2024e). To enroll, these agencies must submit a peer support service description and a supplemental provider agreement in addition to application documents required of other mental health and SUD treatment providers in the state (Pennsylvania DHS 2021).

Challenges

MACPAC's review of the literature identified a number of challenges states face when enrolling Medicaid providers. States may experience difficulty completing the required screening and verification processes within the 60-day timeline CMS recommends due to the volume of applicants and the time and resources required to complete the screenings (CMS 2025a, GAO 2019). Difficulty accessing and using federal databases and needing to conduct manual reviews to reconcile inconsistent provider information across sources can further hinder this process (GAO 2019). Federal and state government agency reports confirm that some states do not consistently implement

required enrollment processes. Previous audits have found state payments to providers who were either not enrolled or did not meet enrollment requirements as well as issues with state compliance with enrollment and screening requirements (Dodaro 2024, OSC 2024, OIG 2020).[43] These payments are considered improper because they were not compliant with federal regulations and do not necessarily indicate fraud (i.e., intentional deception or misrepresentation).

The literature also points to challenges facing providers enrolling in Medicaid, as described below.

Provider burden

The enrollment and credentialing process can be complex and burdensome for providers. Challenges are often most acute for providers in small practices as well as other non-institutional providers (e.g., CHWs, doulas) who are newer to the Medicaid program and lack administrative support for enrollment and credentialing (Moore et al. 2020). Lengthy enrollment and credentialing processes can impose financial hardships for these smaller providers by delaying their ability to bill Medicaid for services delivered to enrollees.

In states with standardized or decentralized credentialing, the administrative burden associated with separate credentialing processes for each managed care plan can discourage providers from participating in more than one managed care network (Allen et al. 2022). Providers may experience additional barriers to credentialing when managed care plans request information beyond what is required by the state's uniform credentialing policy. Furthermore, the enrollment and credentialing processes can be duplicative. For example, some credentialing checks, such as license verification, may also overlap with federally required screening checks (OIG 2013). Additionally, providers seeking to participate in Medicaid may also enroll in commercial plans, whose enrollment requirements may duplicate elements of Medicaid enrollment and credentialing.

Barriers for out-of-state providers

Although federal law allows states to use screenings performed by another state Medicaid program or Medicare, states often rely solely on their own screening process and do not fully leverage data sharing processes to identify when Medicare or another state has screened a provider (Manetto et al. 2020, 42 CFR 455.410). This can lead to duplicative screening for providers that want to serve enrollees outside their state (CHOP 2023, CMS 2022, MACPAC 2020a). When Medicaid patients live near a state border or require specialized care, they may need to travel across state lines to access care (Osamn 2024). In these cases, the provider is required to enroll with the Medicaid program in the patient's home state and be credentialed by the enrollee's managed care plan, if applicable, to receive payment. The requirement to separately enroll and credential with multiple states and managed care plans can burden providers and delay time-sensitive care (Manetto et al. 2020).

Supervisory relationship requirements

Some providers must be supervised by another licensed provider to bill Medicaid. Although these requirements vary by state, supervision is sometimes required for newer types of providers, non-medical providers, limited license holders, or individuals in training. For example, Minnesota requires doulas to be supervised by another Medicaid-enrolled provider (Platt and Kaye 2020). The additional time, effort, and challenges associated with building a supervisory relationship may deter some providers from participating in Medicaid. Providers subject to these requirements may need to provide documentation of these relationships as part of the enrollment process (Pennsylvania DHS 2025a).

Conclusion

The Medicaid provider enrollment and managed care credentialing processes help ensure that only qualified providers render care to enrollees and bill Medicaid for that care, protecting the program from FWA. These processes must be rigorous enough to exclude unqualified providers and those who have committed misconduct. However, complex requirements may present implementation and compliance challenges for states and prevent some providers from participating in Medicaid. The way states operationalize these requirements, including the structure of their credentialing systems, can affect the level of effort

required of providers. Medicaid enrollment and credentialing may be particularly challenging for providers who render services that are newer to Medicaid or who practice in small groups, including those in rural areas.

Further examination of these challenges could help identify potential opportunities to mitigate them. Through interviews with providers and other stakeholders, this research could offer additional insight into barriers faced by certain provider types or challenges related to specific parts of the enrollment and credentialing processes as well as their effects on provider participation, state administrative burden, and program integrity.

Endnotes

[1] The term "provider" refers to both individual and institutional providers as well as suppliers of medical equipment (CMS 2025a). Rendering providers (i.e., providers who render care to patients directly) and ordering, referring, and prescribing (ORP) providers must be enrolled to receive payment for services delivered to Medicaid enrollees (42 CFR 438.602(b), 42 CFR 455.410).

[2] Not all providers who can enroll in Medicaid are licensed. Many provider types who participate in state Medicaid programs, such as community health workers, are not subject to state licensure requirements.

[3] Federal rules require provider credentialing in managed care but do not require it of providers serving Medicaid fee-for-service (FFS) enrollees only (42 CFR 438.214(b)).

[4] The federal enrollment, screening, disclosure, and credentialing requirements apply to providers participating with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) (42 CFR 438.602). Additionally, these requirements apply to primary care case management (PCCM) when the primary care case manager is not already enrolled with the state Medicaid agency (42 CFR 438.602). Federal ownership and control interest disclosure requirements also apply to MCOs, PIHPs, PAHPs, PCCM, and to health insuring organizations (42 CFR 455.101, 42 CFR 455.104).

[5] Medicaid regulations define fraud and abuse. Fraud is defined as intentional deception or misrepresentation, and abuse is defined as provider practices that are unsound and result in unnecessary costs or reimbursement for medically unnecessary services (42 CFR 433.304, 42 CFR 455.2). Waste is not defined in federal regulation but includes inappropriate use of services and resources; it is not criminal or intentional but results in unnecessary costs to Medicaid (MACPAC 2018).

[6] Although many of the federal Medicaid provider enrollment and credentialing requirements also apply to the State Children's Health Insurance Program (CHIP), this chapter focuses on requirements for Medicaid providers.

[7] The screening and enrollment requirements described in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) and the Centers for Medicare & Medicaid Services 2011 final rule originally applied only to Medicaid and CHIP FFS providers (including both rendering and ORP providers) and providers in non–risk-based managed care models (CMS 2025a, 2011a). In a May 2016 final rule, CMS applied the federal screening and disclosure requirements to all remaining providers, including managed care network providers, starting in July 2018 (CMS 2025a, 2016a). The 21st Century Cures Act (Cures Act, P.L. 114-255), enacted in December 2016, set January 2018 as the implementation deadline for applying these requirements (superseding the July 2018 deadline set by the May 2016 final rule) (CMS 2025a, 2016a).

[8] The state Medicaid agency must also "confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of federal databases" (42 CFR 455.436).

[9] The state Medicaid agency must raise a provider's risk level to high when the provider has: (1) an existing Medicaid overpayment, (2) a payment suspension due to a credible allegation of FWA, or (3) an exclusion from participating in Medicaid (including exclusions from other states) within the past decade (42 CFR 455.450(e)). States must also raise the risk level to high when the state Medicaid agency or CMS has lifted a temporary freeze on the enrollment of that provider type within the past six months. Medicaid overpayments refer to situations in which a state Medicaid agency paid a provider an amount that exceeded the allowable amount (42 CFR 433.304).

[10] ORP providers are health care providers who order a service (such as an X-ray) for a patient, refer a patient to another provider, or prescribe a medication to a patient without rendering the service or medication to the patient.

[11] Providers must also attest to their compliance with the advance directive requirements for certain facilities and provider types specified in 42 CFR 489, Subpart I, and 42 CFR 417.436(d).

[12] Federal regulations and guidance do not describe the circumstances in which states may determine that a mandatory denial is not in the best interests of the Medicaid program (CMS 2025a, 42 CFR 455.416).

[13] Value-added services are non-medical services provided voluntarily by managed care plans outside of covered contract services and cannot be built into managed care rates (KFF 2024).

[14] The fee for calendar year 2026 is $750 (CMS 2025b).

[15] Provider types considered institutional by Medicare are also considered institutional by Medicaid and must pay an application fee when enrolling (CMS 2025a, 42 CFR 455.460). If a Medicaid provider type is not recognized by Medicare, states must determine whether that provider type is institutional based on definitions in the Medicaid Provider Enrollment Compendium (CMS 2025a).

[16] The Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16) required the HHS Secretary to issue guidance to states regarding best practices for coordinating care provided by out-of-state providers for children with medically complex conditions, including opportunities to streamline provider enrollment and screening.

[17] CMS requested that state provider revalidation strategies address high-risk providers referenced at 42 CFR 455.450.

[18] For-cause terminations refer to providers terminated for reasons related to fraud, integrity, and quality (CMS 2025a). Not all terminations are for cause, but only for-cause terminations need to be reported to the CMS Data Exchange database of terminated providers (42 CFR 455.417(d)). An example of a non-for-cause termination is when a state terminates a provider's enrollment due to inactivity (CMS 2011b).

[19] States must report terminations when the provider has exhausted state appeal rights or the appeal deadline has passed (CMS 2025a).

[20] Credentialing is part of the provider selection process. Managed care plans must consider two other factors in their provider selection process: non-discrimination and exclusion status. First, plans cannot discriminate against providers who either serve high-risk populations or practice in a specialty that "require[s] costly treatment" when making decisions about whether to include providers in their networks (42 CFR 438.214(c)). Second, plans cannot contract with providers who are excluded from participating in federal health care programs (42 CFR 438.214(d)). Although these required provider selection factors are not explicit credentialing requirements, managed care plans might assess them as part of the credentialing process. Additionally, states can establish additional requirements for provider selection (42 CFR 438.214(e)).

[21] PECOS is an online platform managed by CMS that facilitates enrollment for Medicare providers and suppliers (CMS 2024c).

[22] States may establish provider standards or take action against Medicaid providers only for reasons relating to the fitness of the provider to perform covered medical services or to appropriately bill for those services, and with supporting evidence of the provider's failure to meet the state's reasonable provider standards (CMS 2016b).

[23] Twenty-seven states require that health plans serving Medicaid enrollees be accredited by NCQA (NCQA 2026a). NCQA standards evaluate plans on credentialing and recredentialing, among other areas (NCQA 2026b).

[24] The state has a separate provider enrollment application for "capitation" that appears to be used for specific types of managed care programs (Pennsylvania DHS 2025a).

[25] See 55 Pa. Code § 1101.42 (2024). https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter1101/s1101.42.html&d=reduce.

[26] See 55 Pa. Code § 1101.42 (2024). https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter1101/s1101.42.html&d=reduce. See Ore. Admin. Rule 410-120-1180 (2023). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=306653. See Ohio Admin. Code 5160-1-11 (2021) https://codes.ohio.gov/ohio-administrative-code/rule-5160-1-11. Oregon also considers providers in certain cities within 75 miles of its border (i.e., contiguous areas) as in-state providers.

[27] See 55 Pa. Code § 1101.82 (2024). https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter1101/s1101.82.html&d=reduce.

[28] See Ohio Admin. Code 5160-1-17.8 (2020). https://codes.ohio.gov/ohio-administrative-code/rule-5160-1-17.8.

[29] See Ore. Admin. Rule 410-120-1260 (2024). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=310113.

[30] In Ohio and Oregon, these lists appear to be an additional source that Medicaid providers can check when making decisions about who to employ or enter into ownership agreements with. Representatives from Oregon told MACPAC that the state requires checks of CMS's DEX to determine if enrolling providers have been terminated by Medicare or other state Medicaid programs, though this is not explicitly listed in state regulations.

[31] See Ore. Admin. Rule 410-120-1560 (2023). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=300887.

[32] See Ore. Admin. Rule 410-141-3510 (2024). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=318515.

[33] The Oregon Advisory Committee on Physician Credentialing Information, which is composed of hospital representatives, health care practitioners, and representatives of health service contractors, maintains the standard credentialing and recredentialing forms (OHA 2023).

[34] See 28 Pa. Code § 9.761 (2024). https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/028/chapter9/subchapLtoc.html&d=reduce. CAQH is a non-profit organization that helps streamline the credentialing process and other administrative functions for health plans (PPS 2026).

[35] The report to the Pennsylvania Insurance Department is required of all health maintenance organizations licensed in the state, not just Medicaid managed care organizations.

[36] Under the Individuals with Disabilities Education Act (IDEA, P.L. 101-476), children with disabilities are eligible to receive educational and related services that will help them achieve their educational goals, as documented in each child's IEP, or for infants and toddlers (children younger than age three), the IFSP. States can draw down federal funds under Medicaid to pay for school-based health and related services required by IDEA.

[37] In 2014, CMS clarified that states can receive federal matching funds for medically necessary services for any Medicaid-eligible student, regardless of whether those services are identified in an IEP/IFSP or provided at no cost to other students (CMS 2014). This policy is commonly referred to as the "free care policy reversal."

[38] Some state Medicaid programs do not recognize certain school-based services provider types, such as school psychologists or school social workers, as Medicaid providers.

[39] See Ohio Admin. Code 5160-35-02 (2026). https://codes.ohio.gov/ohio-administrative-code/rule-5160-35-02.

[40] See Ore. Admin. Rule 410-133-0120 (2025). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=321725.

[41] As of October 2023, 25 states have amended their state plans or otherwise expanded coverage to include school-based services that are not part of an IEP/IFSP, as a result of the free care policy reversal. Eighteen states expanded coverage for all services identified as medically necessary, while the remaining states cover a more limited set of services, often including behavioral health care (HSC 2023a).

[42] To enroll in Medicaid in Oregon, peer support specialists must be certified as traditional health workers (OHA 2025g).

[43] For example, a GAO audit found that nearly a quarter of improper Medicaid payments in 2020 ($17.8 billion) were due to states' non-compliance with provider screening and enrollment requirements (Dodaro 2024). Another audit by the HHS OIG found that 40 state Medicaid agencies made $50.3 million in payments to 584 terminated providers from July 2018 through June 2019, and at least $62.3 billion in capitation payments to plans under contracts that did not include provisions to exclude terminated providers from participating in Medicaid managed care, as required by the Cures Act (OIG 2020).

References

Allen, E.H., A. Verdeflor, and C.A. Caraveo. 2022. *Findings from the first year of Medicaid managed care in North Carolina*. Washington, DC: Urban Institute. https://www.urban.org/sites/default/files/2022-11/Findings%20from%20the%20First%20Year%20of%20Medicaid%20Managed%20Care%20in%20North%20Carolina.pdf.

American Public Health Association (APHA). 2025. Community health workers. Washington, DC: APHA. https://www.apha.org/apha-communities/member-sections/community-health-workers.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2025a. *Medicaid provider enrollment compendium (MPEC)*. January 10, 2025. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/program-integrity/downloads/mpec.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2025b. Medicare, Medicaid, and Children's Health Insurance Programs; provider enrollment applications fee amount for calendar year 2026. Notice. *Federal Register* 90, no. 230 (December 3); 55738–55740. https://www.govinfo.gov/content/pkg/FR-2025-12-03/pdf/2025-21877.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2025c. *Report to Congress: Fiscal year 2023: The Centers for Medicare & Medicaid Services' COVID-19 public health emergency response and use of Section 1135 waivers and other flexibilities.* Washington, DC: CMS. https://www.cms.gov/files/document/covid-19-phe-report-congress.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024a. *Comprehensive Medicaid integrity plan for fiscal years 2024–2028.* Baltimore, MD: CMS. https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2024-2028.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024b. Letter from Daniel Tsai to state health officials regarding "Best practices for adhering to early and periodic screening, diagnostic, and treatment (EPSDT) requirements." September 26, 2024. https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024c. *Provider enrollment, chain, and ownership system (PECOS) fact sheet.* Baltimore, MD: CMS. https://www.cms.gov/files/document/pecos-fact-sheet.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024d. *Frequently asked questions on Medicaid and CHIP coverage of peer support services*. Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/faq06052024.pdf.

Center for Medicare & Medicaid Services (CMS). 2024e. Comprehensive Medicaid integrity plan for fiscal years 2024-2028. Washington, DC: CMS. https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2024-2028.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023. *Delivering services in school-based settings: A comprehensive guide to Medicaid services and administrative claiming*. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/financial-management/downloads/sbs-guide-medicaid-services-administrative-claiming.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022. *Summary of public comments in response to the Centers for Medicare & Medicaid Services (CMS) 2022 request for information (RFI): Access to coverage and care in Medicaid and CHIP*. Baltimore, MD: CMS. https://www.medicaid.gov/sites/default/files/2022-12/access-rfi-2022-report.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021. Center for Medicaid and CHIP Services informational bulletin regarding "Guidance on coordinating care provided by out-of-state providers for children with medically complex conditions." https://www.medicaid.gov/federal-policy-guidance/downloads/cib102021.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018. Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of the extension of temporary moratoria on enrollment of Part B non-emergency ground ambulance suppliers and home health agencies in designated geographic locations. Extension of temporary moratoria. *Federal Register* 83, no. 149 (August 2); 37747–37750. https://www.federalregister.gov/documents/2018/08/02/2018-16547/medicare-medicaid-and-childrens-health-insurance-programs-announcement-of-the-extension-of-temporary.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016a. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP delivered in managed care, and revisions related to third party liability. Final rule.

Federal Register 81, no. 88 (May 6); 27498–27901. https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016b. Letter from Vikki Wachino to state Medicaid directors regarding "Clarifying 'free choice of provider' requirement in conjunction with state authority to take action against Medicaid providers." April 19, 2016. Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/smd16005.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016c. Sub regulatory guidance for State Medicaid Agencies regarding "Revalidation." January 11, 2016. https://www.medicaid.gov/medicaid/program-integrity/downloads/revalidation-2016-001.pdf.Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015. Letter from Vikki Wachino to state Medicaid directors regarding "Medicaid/CHIP Provider Fingerprint-Based Criminal Background Check." June 01, 2015. Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/smd060115.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014. Letter from Cindy Mann to state Medicaid directors regarding "Medicaid payment for services provided without charge (free care)." December 15, 2014. Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013. Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of temporary moratoria on enrollment of ambulances suppliers and providers and home health agencies in designated geographic areas. Notice. *Federal Register* 78, no. 147 (July 31); 46339–46347. https://www.federalregister.gov/documents/2013/07/31/2013-18394/medicare-medicaid-and-childrens-health-insurance-programs-announcement-of-temporary-moratoria-on.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2011a. Medicare, Medicaid, and Children's Health Insurance Programs; additional screening requirements, application fees, temporary enrollment moratoria, payment suspensions and compliance plans for providers and suppliers. Final rule. *Federal Register* 76, no. 22 (February 2); 5862–5971. https://www.federalregister.gov/documents/2011/02/02/2011-1686/medicare-medicaid-and-childrens-health-insurance-programs-additional-screening-requirements.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2011b. Center for Program Integrity informational bulletin regarding "Termination of Provider Participation under Medicaid if Terminated under Medicare or other State Plan." May 31, 2011. https://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/6501-term.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2026a. Letter from Mehmet Oz to state Medicaid directors regarding a two-year strategy for Medicaid provider revalidation. April 23, 2026.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2026b. Letter from Mehmet Oz to governors regarding revalidation of Medicaid providers. April 23, 2026.

Chen, A. 2022. *Current state of doula Medicaid implementation efforts in November 2022.* Washington, DC: National Health Law Program. https://healthlaw.org/current-state-of-doula-medicaid-implementation-efforts-in-november-2022/.

Children's Hospital of Philadelphia (CHOP). 2023. Letter from Ahaviah D. Glaser to Seema Verma regarding "Coordinating care from out-of-state providers for Medicaid-eligible children with medically complex conditions; *Federal Register*, vol. 85, no. 13, January 21, 2020 [CMS–2324-NC]." June 3, 2020. https://www.regulations.gov/comment/CMS-2020-0006-0081.

D'Alessandro, M., E. Higgins, and S. Wilkniss. 2024. Updates and FAQs: Developing and implementing a Medicaid state plan amendment to authorize community health worker reimbursement. *NASHP Blog*, August 5. https://nashp.org/updates-and-faqs-developing-and-implementing-a-medicaid-state-plan-amendment-to-authorize-community-health-worker-reimbursement/.

Division of TennCare. 2022. *TennCare policy manual*. Nashville, TN: Division of TennCare. https://www.tn.gov/content/dam/tn/tenncare/documents2/pro16001.pdf.

Dodaro, G.L. 2024. Medicare and Medicaid: Additional actions needed to enhance program integrity and save billions. Testimony before the Energy and Commerce Committee, Subcommittee on Oversight and Investigations, U.S. House of Representatives. April 16, 2024. https://www.gao.gov/assets/gao-24-107487.pdf.

Haldar, S., and E. Hinton. 2023. *State policies for expanding Medicaid coverage of community health worker (CHW) services.* Washington, DC: KFF. https://www.kff.org/medicaid/issue-brief/state-policies-for-expanding-medicaid-coverage-of-community-health-worker-chw-services/#footnote-576635-9.

Healthy Schools Campaign (HSC). 2023a. *School Medicaid expansion: How (and how many) states have taken action to increase school health access and funding.* Chicago, IL: HSC. https://healthyschoolscampaign.org/dev/wp-content/uploads/2023/10/Status-of-School-Medicaid-Expansion_-How-and-How-Many-States-Have-Taken-Action-to-Increase-School-Health-Access-and-Funding.pdf.

Healthy Schools Campaign (HSC). 2023b. *School Medicaid survey*. Chicago, IL: HSC. https://healthystudentspromisingfutures.org/wp-content/uploads/2023/06/School-Medicaid-Survey.pdf.

Interstate Medical Licensure Compact (IMLC). 2021. A faster pathway to physician licensure. Littleton, CO: IMLC. https://imlcc.com/a-faster-pathway-to-physician-licensure/.

KFF. 2024. Medicaid MCO enrollment by plan and parent firm, 2024. Washington, DC: KFF. https://www.kff.org/other/state-indicator/medicaid-enrollment-by-mco/.

KFF. 2022. Medicaid behavioral health services: Peer support services. Washington, DC: KFF. https://www.kff.org/other/state-indicator/medicaid-behavioral-health-services-peer-support-services/.

Manetto, N., J. Greenberg, and C. Reddy, 2020. Policies to enhance care of out-of-state pediatric Medicaid beneficiaries. *Health Affairs Forefront*, October 6. https://www.healthaffairs.org/content/forefront/policies-enhance-care-out-of-state-pediatric-medicaid-beneficiaries.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022. *Medicaid coverage of community health worker services.* Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2022/04/Medicaid-coverage-of-community-health-worker-services-1.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020a. *Medicaid payment policy for out-of-state hospital services.* Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid-Payment-Policy-for-Out-of-State-Hospital-Services.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020b. *Section 1135 waivers*. Washington, DC: MACPAC. https://www.macpac.gov/subtopic/section-1135-waivers/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018. *Program Integrity*. Washington, DC: MACPAC. https://www.macpac.gov/subtopic/program-integrity/.

Moore, J.E., K.E. George, C. Bakst, and K. Shea. 2020. Improving maternal health access, coverage, and outcomes in Medicaid. Washington, DC: Institute for Medicaid Innovation. https://medicaidinnovation.org/wp-content/uploads/2022/11/2020-IMI-Improving_Maternal_Health_Access_Coverage_and_Outcomes-Report-2.pdf.

National Academy for State Health Policy (NASHP). 2025a. State community health worker policies: Ohio. Washington, DC: NASHP. https://nashp.org/state-tracker/state-community-health-worker-policies/ohio/.

National Academy for State Health Policy (NASHP). 2025b. State community health worker policies: Pennsylvania. Washington, DC: NASHP. https://nashp.org/state-tracker/state-community-health-worker-policies/pennsylvania/.

National Committee for Quality Assurance (NCQA). 2026a. Making the most of accreditation. Washington, DC: NCQA. https://www.ncqa.org/public-policy/maximizing-the-use-of-accreditation/.

National Committee for Quality Assurance (NCQA). 2026b. Health plan accreditation. Washington, DC: NCQA. https://www.ncqa.org/programs/health-plans/health-plan-accreditation-hpa/.

Office of Inspector General (OIG), U.S. Department of Health and Human Services. 2020. *States could do more to prevent terminated providers from serving Medicaid beneficiaries.* Washington, DC: OIG. https://oig.hhs.gov/documents/evaluation/2801/OEI-03-19-00070-Complete%20Report.pdf.

Office of Inspector General (OIG), U.S. Department of Health and Human Services. 2013. *State and CMS oversight of the Medicaid managed care credentialing process.* Washington, DC: OIG. https://oig.hhs.gov/documents/evaluation/3107/OEI-09-10-00270-Complete%20Report.pdf.

Office of the New York State Comptroller (OSC). 2024. *Medicaid program: Managed care payments to unenrolled providers.* Albany, NY: OSC. https://www.osc.ny.gov/files/state-agencies/audits/pdf/sga-2024-21s6.pdf.

Ohio Council of Behavioral Health & Family Services Providers (Ohio Council). 2023. Ohio Medicaid provider site visits. Columbus, OH: Ohio Council. https://obc.memberclicks.net/ohio-medicaid-provider-site-visits.

Ohio Department of Medicaid (ODM). 2025a. Provider enrollment: Common questions about provider enrollment. Columbus, OH: ODM. https://medicaid.ohio.gov/resources-for-providers/enrollment-and-support/provider-enrollment/support/.

Ohio Department of Medicaid (ODM). 2025b. Provider network management (PNM): Frequently asked questions. Columbus, OH: ODM. https://medicaid.ohio.gov/resources-for-providers/nextgeneration-pnm/support.

Ohio Department of Medicaid (ODM). 2025c. Federal and state requirements for revalidation and recredentialing. Columbus, OH: ODM. https://medicaid.ohio.gov/resources-for-providers/enrollment-and-support/frrr/federal-requirement-for-revalidation-reenrollment.

Ohio Department of Medicaid (ODM). 2024a. Doula training webinar series. Presentation for doula training, September 10, 2024. https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Families%2C%20Individuals/Programs/MISP/Doula_Training_Series_Session_One_10Sept24.pdf.

Ohio Department of Medicaid (ODM). 2024b. *Provider enrollment and billing guidance for behavioral health peer support service.* August 12, 2024. Columbus, OH: ODM. https://content.govdelivery.com/accounts/OHMEDICAID/bulletins/3ade598.

Ohio Department of Medicaid (ODM). 2023. *Centralized credentialing: Frequently asked questions—December 2023*. Columbus, OH: ODM. https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/a5f85cde-5a6e-431b-9f93-fd897675160e/Centralized+Credentialing+FAQ.pdf?MOD=AJPERES&CVID=oV28lJ6.

Ohio Department of Medicaid (ODM). 2022a. *New provider enrollment questions and answers.* September 29, 2022. Columbus, OH: ODM. https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Providers/Enrollment%20and%20Support/NewProviderEnrollment-FAQs_2024%20(1).pdf.

Ohio Department of Medicaid (ODM). 2022b. *Federal requirement for revalidation questions and answers.* February 14, 2022. Columbus, OH: ODM. https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/BH/provider/MITSBITS/2016/ProviderRevalidation-FAQs%20(1).pdf.

Ohio Department of Medicaid (ODM). 2022c. *Credentialing guide and requirements*. Columbus, OH: ODM. https://medicaid.ohio.gov/wps/wcm/connect/gov/8be18a92-41a9-4039-aeee-8791f278ae93/%5BFinal%5D+Credentialing+Guide+and+Requirements.pdf?MOD=AJPERES&CVID=p1LHZ1p.

Oregon Health Authority (OHA). 2025a. Oregon Health Plan (OHP) provider enrollment. Salem, OR: OHA. https://www.oregon.gov/oha/hsd/ohp/pages/provider-enroll.aspx.

Oregon Health Authority (OHA). 2025b. *Oregon Health Plan: Amended and restated health plan services contract.* Salem, OR: OHA. https://www.oregon.gov/oha/HSD/OHP/CCO/2025-Medicaid-Contract-Template.pdf.

Oregon Health Authority (OHA). 2025c. Oregon Health Plan provider revalidation. Salem, OR: OHA. https://www.oregon.gov/oha/hsd/ohp/pages/revalidation.aspx.

Oregon Health Authority (OHA). 2025d. School-based health services program. Salem, OR: OHA. https://www.oregon.gov/oha/hsd/ohp/pages/policy-sbhs.aspx.

Oregon Health Authority (OHA). 2025e. *School-based health services (SBHS): Provider enrollment instructions.* Salem, OR: OHA. https://www.oregon.gov/oha/HSD/OHP/Tools/SBHS-Provider-Enrollment-Instructions.pdf.

Oregon Health Authority (OHA). 2025f. *Birth doula fee-for-service (open card) billing guide.* Salem, OR: OHA. https://www.oregon.gov/oha/EI/THW%20Documents/Doula-Billing-Guide.pdf.

Oregon Health Authority (OHA). 2025g. Peer support specialist (PSS). Salem, OR: OHA. https://www.oregon.gov/oha/ei/pages/thw-pss.aspx.

Oregon Health Authority (OHA). 2025h. *Behavioral health peer-delivered services fee-for-service (open card) billing guide.* January 2024. *Salem*, OR: OHA. https://www.oregon.gov/oha/HSD/OHP/Tools/Peer-Support-Billing-Guide.pdf.

Oregon Health Authority (OHA). 2024a. Oregon Medicaid form for "Provider enrollment information: Payable individuals and organizations. Salem, OR: OHA. https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le3972.pdf.

Oregon Health Authority (OHA). 2024b. *Oregon practitioner credentialing application.* May 2024. Salem, OR: OHA. https://www.oregon.gov/oha/HPA/OHIT-ACPCI/Documents/2024-OPCA-Final.pdf.

Oregon Health Authority (OHA). 2024c. *Community health worker (CHW) fee-for-service (open card) billing guide.* January 2024. Salem, OR: OHA. https://www.oregon.gov/oha/HSD/OHP/Tools/CHW-Billing-Guide.pdf.

Oregon Health Authority (OHA). 2023. *Charter—Advisory Committee on Physician Credentialing Information (approved January 2023).* Salem, OR: OHA. https://www.oregon.gov/oha/HPA/OHIT-ACPCI/Documents/ACPCI_Charter.pdf.

Oregon Health Authority (OHA). 2021. *CMS provider types and risk categories.* November 5, 2021. Salem, OR: OHA. https://www.oregon.gov/oha/HSD/OHP/Tools/CMS-Provider-Risk-Categories.pdf.

Oregon Medical Board (OMB). 2025. Interstate Medical Licensure Compact and Oregon. Portland, OR: OMB. https://www.oregon.gov/omb/topics-of-interest/pages/interstate-medical-licensure-compact-and-oregon.aspx.

Osamn, M. 2024. Groups urge Congress to pass key rare disease bills during lame-duck. *Inside Health Policy*, November 18. https://insidehealthpolicy.com/daily-news/groups-urge-congress-pass-key-rare-disease-bills-during-lame-duck.

PacificSource Community Solutions. 2024. *Medicaid provider enrollment FAQ.* Bend, OR: PacificSource Community Solutions. https://pacificsource.com/sites/default/files/2024-12/PRV432_1221_MedicaidProviderEnrollment_Guide.pdf.

Pennsylvania Department of Human Services (Pennsylvania DHS). 2025a. Provider enrollment documents. Harrisburg, PA: Pennsylvania DHS. https://www.pa.gov/agencies/dhs/resources/for-providers/provider-enrollment-information/provider-enrollment-documents.html.

Pennsylvania Department of Human Services (Pennsylvania DHS). 2025b. *HealthChoices agreement.* Harrisburg, PA: Pennsylvania DHS. https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/providers/documents/managed-care-information/2025-health-choices-agreement-including-exhibits-and-non-rate-financial-appendices-draft-pending-commonwealth-signatures-and-cms-approval.pdf.

Pennsylvania Department of Human Services (Pennsylvania DHS). 2025c. *Doula FAQ document.* Harrisburg, PA: Pennsylvania DHS. https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/providers/documents/Provider-Enrollment-Doula-FAQ.pdf.

Pennsylvania Department of Human Services (Pennsylvania DHS). 2024a. Getting started with MA FFS enrollment training. Provider enrollment training webinar, November 22, 2024. https://www.youtube.com/watch?v=LSb0T35-veo-&t=6s.

Pennsylvania Department of Human Services (Pennsylvania DHS). 2024b. *HealthChoices Agreement.* Harrisburg, PA: Pennsylvania DHS. https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/providers/documents/managed-care-information/2024-HealthChoices-Agreement-Including-Exhibits-and-Non-financial-Appendices.pdf.

Pennsylvania Department of Human Services (Pennsylvania DHS). 2024c. *Pennsylvania Department of Human Services School-Based ACCESS program handbook.* Harrisburg, PA: Pennsylvania DHS. https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/documents/school-based-access-program/2024-sbap-handbook.pdf.

Pennsylvania Department of Human Services (Pennsylvania DHS). 2024d. Informational bulletin from Sally Kozak regarding "Coverage of and payment for doula services in the Medical Assistance Program." December 23, 2024. https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/mab2024122309.pdf.

Pennsylvania Department of Human Services (Pennsylvania DHS). 2024e. Welcome to Pennsylvania certified perinatal doula enrollment training. Provider enrollment training presentation for doula providers, October 1, 2024. https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/providers/documents/Perinatal-DOULA-Enrollment-Presentation-01102024.pdf.

Pennsylvania Department of Human Services (Pennsylvania DHS). 2024f. Informational bulletin from Jennifer S. Smith regarding "Peer support services." December 20, 2024. https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/services/mental-health-in-pa/documents/peer-support/ohmsas-24-05-peer-services-bulletin-12-20-20.pdf.

Pennsylvania Department of Human Services (Pennsylvania DHS). 2022a. *Ordering, referring and prescribing provider enrollment requirements.* Harrisburg, PA: Pennsylvania DHS. https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/for-providers/documents/remittance-advice-alerts_promise-banner/Banner%201544.pdf.

Pennsylvania Department of Human Services (Pennsylvania DHS). 2022b. *Electronic provider enrollment application manual*. Harrisburg, PA: Pennsylvania DHS. https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/providers/documents/chip-provider-enrollment/Electronic%20Provider%20Enrollment%20User%20Manual%20v1.1.pdf.

Pennsylvania Department of Human Services (Pennsylvania DHS). 2021. *Requirements for provider type 11—mental health/substance abuse services.* Harrisburg, PA: Pennsylvania DHS. https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/billing-info/documents/provider-enrollment-docs/Mental%20Health%20Substance%20Abuse%20Provider%20Requirements.pdf.

Pennsylvania Department of Human Services (Pennsylvania DHS). 2017a. *Requirements of the Affordable Care Act.* https://www.paproviders.org/wp-content/uploads/2017/08/DHS-ORP-Presentation-8.16.20171.pdf.

Pennsylvania Department of Human Services (Pennsylvania DHS). 2016a. Informational bulletin from Leesa M. Allen regarding "Enrollment of ordering, referring and prescribing providers." April 1, 2016. https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/c_224393.pdf.

Pennsylvania Department of Human Services (Pennsylvania DHS). 2016b. Informational bulletin from Leesa M. Allen regarding "Assignment of ACA categorical risk levels and the implementation of site visits." August 4, 2016. https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/c_235991.pdf.

Pennsylvania Department of Human Services (Pennsylvania DHS). 2016c. Informational bulletin from Leesa M. Allen regarding "Revalidation of medical assistance (MA) providers." May 26, 2016. https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/forms-and-pubs-omap/c_228794.pdf.

Physician Practice Specialists (PPS). 2026. How to register with CAQH & why it matters to your practice. Jacksonville, FL: PPS. https://physicianpracticespecialists.com/credentialing/what-is-caqh-and-why-matters-to-your-practice/.

Platt, T., and N. Kaye. 2020. *Four state strategies to employ doulas to improve maternal health and birth outcomes in Medicaid.* Washington, DC: National Academy for State Health Policy. https://nashp.org/four-state-strategies-to-employ-doulas-to-improve-maternal-health-and-birth-outcomes-in-medicaid/.

Substance Abuse and Mental Health Services Administration (SAMHSA). 2024. *Peer support specialists: A growing mental health and addictions workforce.* Rockville, MD: SAMHSA. https://library.samhsa.gov/sites/default/files/peer-support-mh-addictions-workforce-pep24-08-005.pdf.

U.S. Department of Education (ED). 2024. *Medicaid funding for school-based services*. Washington, DC: U.S. Department of Education. https://www.ed.gov/sites/ed/files/about/offices/list/osers/docs/medicaid-funding-for-school-based-services-03-08-2024.pdf.

U.S. Government Accountability Office (GAO). 2019. *Medicaid providers: CMS oversight should ensure state implementation of screening and enrollment requirements.* Washington, DC: GAO. https://www.gao.gov/assets/d208.pdf.

UnitedHealthcare. 2025. *UnitedHealthcare credentialing plan 2025–2027*. Minnetonka, MN: UnitedHealthcare. https://www.uhcprovider.com/content/dam/provider/docs/public/resources/join-network/Credentialing-Plan.pdf.

APPENDIX 7A: Federal Requirements

TABLE 7A-1. Timeline of Federal Medicaid and CHIP Enrollment, Screening, and Disclosure Policies and Requirements as of May 2025

Policy or requirement	Effective date	Applicable to	Reference
Certain entities must disclose information about ownership and control	October 1978; amended versions effective March 2011 and January 2024	Disclosing entities, fiscal agents, and managed care plans[1]	42 CFR 455.104
State Medicaid agencies must have an agreement with Medicaid providers	October 1978; amended versions effective October 1979, April 1992, and July 2010	All Medicaid providers and organizations furnishing services under the state plan	42 CFR 431.107
State plans must pay for services provided to beneficiaries out of state (under certain circumstances)	October 1978	Out-of-state providers	42 CFR 431.52
Providers must disclose information about business transactions and persons convicted of crimes	October 1978	All Medicaid providers who have an agreement with the state Medicaid agency	42 CFR 455.105-106
Provider agreements can be retroactive for up to one year if certain conditions are met	September 1997	Accredited providers who have met all federal and state (when applicable) requirements, as determined by CMS	42 CFR 431.108
Each state must establish their own uniform credentialing and recredentialing policies	June 2003[2]	MCO, PIHP, or PAHP network providers	42 CFR 438.214
Managed care plans must follow a documented process for credentialing and recredentialing	June 2003	MCO, PIHP, or PAHP network providers	42 CFR 438.214
State Medicaid agencies must screen all enrolled providers	March 2011; amended version effective October 2021	All FFS and non-risk-based managed care rendering and ORP providers	42 CFR 455.410

TABLE 7A-1. (continued)

Policy or requirement	Effective date	Applicable to	Reference
State Medicaid agencies must enroll all ORP providers	March 2011	All FFS and non-risk-based managed care rendering and ORP providers	42 CFR 455.410
State Medicaid agencies must complete certain enrollment and screening activities	March 2011	All FFS and non-risk-based managed care rendering and ORP providers	42 CFR 455.412, 455.434, and 455.436
State Medicaid agencies can require additional screening or impose temporary moratoria	March 2011	All FFS and non-risk-based managed care rendering and ORP providers	42 CFR 455.452 and 455.470
State Medicaid agencies must terminate enrolled providers or deny enrollment to providers under specific circumstances	March 2011; amended version effective January 2024	All FFS and non-risk-based managed care rendering and ORP providers	42 CFR 455.416
Medicaid provider enrollment and screening requirements and disclosure of affiliation requirement apply to CHIP providers	March 2011; amended version effective November 2019	All FFS and non-risk-based managed care rendering and ORP CHIP providers	42 CFR 457.990
State Medicaid agencies must revalidate the enrollment of providers who were enrolled as of March 25, 2011, by March 24, 2016	Guidance issued December 2011	Providers enrolled as of March 25, 2011	CMS 2011b
State Medicaid agencies must begin implementing the fingerprint-based background check requirement	Guidance issued June 2015	All FFS and non-risk-based managed care rendering and ORP providers designated as high risk	CMS 2015
States must complete the initial set of revalidations by September 25, 2016 (instead of March 24, 2016)	Guidance issued January 2016	All FFS and non-risk-based managed care rendering and ORP providers enrolled on or before September 25, 2011	CMS 2016c

TABLE 7A-1. (continued)

Policy or requirement	Effective date	Applicable to	Reference
State Medicaid agencies must comply with (or have a compliance plan approved by CMS for) the fingerprint-based criminal background check screening requirement by June 1, 2016	Guidance issued January 2016	All FFS and non-risk-based managed care rendering and ORP providers designated as high risk	CMS 2016d
CMS interpretation of federal statute is that provider agreements are equivalent to provider enrollment applications in Medicaid[3]	May 2016	N/A	CMS 2016a
States must require managed care plans to submit information on ownership and control	July 2017	Managed care plans	42 CFR 438.604
States must screen, enroll, and collect disclosures from all managed care network providers	January 2018	Managed care network providers	42 CFR 438.602
Providers must disclose information about affiliations with providers who have a disclosable event	March 2020	Medicaid and CHIP providers enrolling for the first time	42 CFR 455.107
States must select an option for the disclosure of affiliations requirement; they can choose to require it at initial enrollment or upon request	March 2020	N/A	42 CFR 455.107
States must allow Medicare-enrolled providers to enroll for determining Medicare cost sharing	October 2021	All Medicare-enrolled providers (including provider types the state does not recognize)	42 CFR 455.410
States allowed to change their selection of the disclosure of affiliation option from upon request to at initial enrollment	January 2023	N/A	42 CFR 455.107

TABLE 7A-1. (continued)

Policy or requirement	Effective date	Applicable to	Reference
Regulations established for the DEX provider termination database, reasons that require a provider to be added to it, and the process for determining how long terminated providers remain in the database	January 2024	Terminated Medicaid and CHIP providers	42 CFR 455.417
Nursing facilities must disclose additional information such as members of their governing body, officers, directors, members, partners, trustees, and managing employees	January 2024	Medicaid nursing facility providers	42 CFR 455.104

Notes: Managed care plans are managed care organizations (MCOs), prepaid inpatient health plans (PIHPS), prepaid ambulatory health plans (PAHPs), and primary care case management (PCCM). CMS is Centers for Medicare & Medicaid Services. FFS is fee for service. ORP is ordering, referring, and prescribing. CHIP is State Children's Health Insurance Program. N/A is not applicable. DEX is Data Exchange System.

[1] Disclosure requirements at 42 CFR 455.104 apply also to health insuring organizations.

[2] Although the effective date of the regulation was August 2002, states had until June 2003 to come into compliance.

[3] Provider enrollment applications are not explicitly required by federal regulations but are referenced in Medicare and Medicaid program integrity statute. CMS equated the reference to "applications [for providers] to enroll" in Medicaid in Section 1128J(e) of the Social Security Act to the provider agreement with the state Medicaid agency (§ 1128J(e) of the Social Security Act and CMS 2016a).

Sources: 42 CFR 431.52, 431.107, 431.108, 438.214, 438.602, 438.604, Part 455 Subpart E, 455.104, 455.105–106, 455.410, 455.416, 455.417, 457.990; CMS 2016a, 2016b, 2016c, 2015, 2011b.

TABLE 7A-2. Federal Disclosure Requirements and Applicability as of May 2025

Topic	Timing	Disclosures	Applicability
Ownership and control	• Before executing the provider agreement • Upon request by the state Medicaid agency during revalidation • Within 35 days of a change in ownership	• Personal information (e.g., name, address, tax identification number) of individuals and corporations with an ownership or controlling interest in the disclosing entity • Any personal relationships between people with ownership and control interests in the disclosing entity • Whether the owner also has an ownership or control interest in any other disclosing entity; if so, the name of the disclosing entity • Personal information about managing employees of the disclosing entity (e.g., name, Social Security number)	• Disclosing entities, which include all providers except individuals or those who are part of a group of individuals • Fiscal agents (i.e., state Medicaid agency contractors that process claims) • Managed care entities (i.e., MCOs, PIHPs, PAHPs, PCCM, HIOs)
Business transactions	• Within 30 days upon request from the HHS Secretary or the state Medicaid agency	• Ownership information about subcontractors with which the provider has had business transactions greater than $25,000 in the past year • Certain business transactions between the provider and wholly owned supplier or subcontractors within the past five years	• All Medicaid providers that enter into an agreement with the state Medicaid agency

TABLE 7A-2. (continued)

Topic	Timing	Disclosures	Applicability
Persons convicted of crimes	• Before the provider agreement is executed or renewed, or upon request by the state Medicaid agency	• Ownership information about subcontractors with which the provider has had business transactions greater than $25,000 in the past year • Certain business transactions between the provider and wholly owned supplier or subcontractors within the past five years	• All Medicaid providers that enter into an agreement with the state Medicaid agency
Affiliations	• States can choose whether to require this disclosure upon request or at the time of initial enrollment	• The identity of any person who has ownership or control interest in, or is an agent or managing employee of, the provider who has been convicted of a crime related to their involvement in federal health programs	• All Medicaid providers that enter into an agreement with the state Medicaid agency

Notes: MCO is managed care organization. PIHP is prepaid inpatient health plan. PAHP is prepaid ambulatory health plan. PCCM is primary care case management. HIO is health insuring organization. HHS Secretary is Secretary of the U.S. Department of Health and Human Services. CHIP is State Children's Health Insurance Program.

Source: 42 CFR 455.104-107.

APPENDIX 7B: Databases

TABLE 7B-1. Databases Used to Screen Medicaid Providers

Database	Contents	Frequency of federally required checks	Administered by
Federally required			
DMF	Deceased individuals with Social Security numbers	At enrollment and revalidation[1]	SSA
LEIE	Individuals and entities excluded from participating in federal health care programs due to criminal convictions for health care fraud and other health care–related crimes	At enrollment and revalidation, then at least monthly	HHS OIG
NPPES	National provider identifiers, unique numbers assigned to practicing health care providers and organizations	At enrollment and revalidation	CMS
SAM exclusions list[2]	Individuals and entities excluded from receiving federal contracts	At enrollment and revalidation, then at least monthly	GSA
DEX	Providers who have been terminated from Medicaid or Medicare, plus data from DMF and PECOS	N/A	CMS
Optional			
PECOS	Medicare provider enrollment data	N/A	CMS
State-maintained databases	Providers terminated from a state's Medicaid program	N/A	State agencies

Notes: DMF is Death Master File. SSA is Social Security Administration. LEIE is List of Excluded Individuals/Entities. HHS OIG is U.S. Department of Health and Human Services Office of Inspector General. NPPES is National Plan and Provider Enumeration System. CMS is Centers for Medicare & Medicaid Services. SAM is System for Award Management. GSA is General Services Administration. DEX is Data Exchange System. PECOS is Provider Enrollment, Chain, and Ownership System. N/A is not applicable. The list of optional databases was identified through a review of publicly available documents in select states and is not meant to be exhaustive.

[1] P.L. 119-21, an act to provide for reconciliation pursuant to Title II of H. Con. Res. 14, requires states to check the DMF quarterly to determine if a provider is deceased and to disenroll any deceased providers, effective January 1, 2028.

[2] The regulation specifies the Excluded Parties List System, which was replaced by SAM.

Sources: MACPAC and Acumen, LLC, 2025, analysis of publicly available documents in Ohio, Oregon, and Pennsylvania; CMS 2025a, GAO 2019.

Appendix

Authorizing Language (§ 1900 of the Social Security Act)

Medicaid and CHIP Payment and Access Commission

(a) ESTABLISHMENT.—There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as ‘‘MACPAC’’).

(b) DUTIES.—

(1) REVIEW OF ACCESS POLICIES FOR ALL STATES AND ANNUAL REPORTS.—MACPAC shall—

(A) review policies of the Medicaid program established under this title (in this section referred to as ‘‘Medicaid’’) and the State Children’s Health Insurance Program established under title XXI (in this section referred to as ‘‘CHIP’’) affecting access to covered items and services, including topics described in paragraph (2);

(B) make recommendations to Congress, the Secretary, and States concerning such access policies;

(C) by not later than March 15 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC’s recommendations concerning such policies; and

(D) by not later than June 15 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

(2) SPECIFIC TOPICS TO BE REVIEWED.—Specifically, MACPAC shall review and assess the following:

(A) MEDICAID AND CHIP PAYMENT POLICIES.—Payment policies under Medicaid and CHIP, including—

(i) the factors affecting expenditures for the efficient provision of items and services in different sectors, including the process for updating payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services;

(ii) payment methodologies; and

(iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries (including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations).

(B) ELIGIBILITY POLICIES.—Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

(C) ENROLLMENT AND RETENTION PROCESSES.—Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

(D) COVERAGE POLICIES.—Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.

(E) QUALITY OF CARE.—Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.

(F) INTERACTION OF MEDICAID AND CHIP PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this title or title XXI and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.

(G) INTERACTIONS WITH MEDICARE AND MEDICAID.—Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dually eligible individuals.

(H) OTHER ACCESS POLICIES.—The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers and preventive, acute, and long-term services and supports.

(3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—MACPAC shall—

(A) review national and State-specific Medicaid and CHIP data; and

(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.

(4) CREATION OF EARLY-WARNING SYSTEM.—MACPAC shall create an early-warning system to identify provider shortage areas, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.

(5) COMMENTS ON CERTAIN SECRETARIAL REPORTS AND REGULATIONS.—

(A) CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress and the Secretary written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

(B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.

(6) AGENDA AND ADDITIONAL REVIEWS.—

(A) IN GENERAL.—MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC's agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.

(B) REVIEW AND REPORTS REGARDING MEDICAID DSH.—

(i) IN GENERAL.—MACPAC shall review and submit an annual report to Congress on disproportionate share hospital payments under section 1923. Each report shall include the information specified in clause (ii).

(ii) REQUIRED REPORT INFORMATION.—Each report required under this subparagraph shall include the following:

(I) Data relating to changes in the number of uninsured individuals.

(II) Data relating to the amount and sources of hospitals' uncompensated care costs, including the amount of such costs that are the result of providing unreimbursed or under-reimbursed services, charity care, or bad debt.

(III) Data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quarternary care, including the provision of trauma care and public health services.

(IV) State-specific analyses regarding the relationship between the most recent State DSH allotment and the projected State DSH allotment for the succeeding year and the data reported under subclauses (I), (II), and (III) for the State.

(iii) DATA.—Notwithstanding any other provision of law, the Secretary regularly shall provide MACPAC with the most recent State reports and most recent independent certified audits submitted under section 1923(j), cost reports submitted under title XVIII, and such other data as MACPAC may request for purposes of conducting the reviews and preparing and submitting the annual reports required under this subparagraph.

(iv) SUBMISSION DEADLINES.—The first report required under this subparagraph shall be submitted to Congress not later than February 1, 2016. Subsequent reports shall be submitted as part of, or with, each annual report required under paragraph (1)(C) during the period of fiscal years 2017 through 2024.

(7) AVAILABILITY OF REPORTS.—MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(8) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term ''appropriate committees of Congress'' means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(9) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

(10) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations.

(11) CONSULTATION AND COORDINATION WITH MEDPAC.—

(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as ‘‘MedPAC’’) established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

(B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

(12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC's recommendations and reports.

(13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dually eligible individuals.

(14) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.—MACPAC's authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary's authority to carry out Federal responsibilities with respect to Medicaid and CHIP.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dually eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.

(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.

(D) ETHICAL DISCLOSURE.—The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

(3) TERMS.—

(A) IN GENERAL.—The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.

(4) COMPENSATION.—While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member's term.

(6) MEETINGS.—MACPAC shall meet at the call of the Chairman.

(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may—

(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal and State departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes (41 USC 5));

(4) make advance, progress, and other payments which relate to the work of MACPAC;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.

(e) POWERS.—

(1) OBTAINING OFFICIAL DATA.—MACPAC may secure directly from any department or agency of the United States and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP, information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.

(2) DATA COLLECTION.—In order to carry out its functions, MACPAC shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

(C) adopt procedures allowing any interested party to submit information for MACPAC's use in making reports and recommendations.

(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.

(4) PERIODIC AUDIT.—MACPAC shall be subject to periodic audit by the Comptroller General of the United States.

(f) FUNDING.—

(1) REQUEST FOR APPROPRIATIONS.—MACPAC shall submit requests for appropriations (other than for fiscal year 2010) in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.

(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

(3) FUNDING FOR FISCAL YEAR 2010.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

(B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, $2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

(4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.

Biographies of Commissioners

Verlon Johnson, MPA, (Chair), 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.

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

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

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

Doug Brown, RPh, MBA, is senior vice president of value and access at 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. Before 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 of business administration from Virginia Commonwealth University.

Jennifer L. Gerstorff, FSA, MAAA, is a partner 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 work groups, participating in research efforts, developing content for continuing education opportunities, and facilitating monthly public interest group discussions with Medicaid actuaries and other industry experts. She received her bachelor in applied mathematics from Columbus State University.

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

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

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

Timothy Hill, MPA, is an experienced health policy executive. Mr. Hill held several executive positions within the Centers for Medicare & Medicaid Services, 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.

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

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

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

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 the 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.

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.

Biographies of Staff

Annie Andrianasolo, MBA, is the chief administrative officer. Most recently, Andrianasolo managed the chief executive officer's office at the Pharmaceutical Research and Manufacturers of America. Andrianasolo previously worked for various nonprofit organizations, including the Public Health Institute, the Minneapolis Foundation, and the World Bank. Andrianasolo holds a bachelor of arts in economics from the University of the District of Columbia and a master of business administration from Johns Hopkins University.

Ranjani Anirudhan, MPH, is a research assistant. Before joining MACPAC, Anirudhan worked as a Title V Maternal and Child Health intern for the Nevada State Health Department and was a Teach for America corps member, working in low-income schools at the intersection of health and education. Anirudhan received a master of public health from The George Washington University and a bachelor of science in neuroscience from the University of Texas at Austin.

Nyoka Arnold is the human resources specialist. Arnold is a seasoned human resources professional with a focused expertise in payroll, benefits administration, and recruitment. Arnold previously served as a human resources specialist at the U.S. Department of Energy, supporting payroll and benefits administration and contributing to recruitment initiatives. Arnold earned an associate of arts with a concentration in human resource development from Prince George's Community College and has completed benefits training through Graduate School USA.

Gabby Ballweg is an analyst. Before joining MACPAC, Ballweg worked as the project coordinator for the Wisconsin Community Health Empowerment Fund and interned at Action on Smoking and Health. Ballweg graduated from the University of Wisconsin, Madison, with a bachelor of science in biology and political science.

Kirstin Blom, MIPA, is a policy director. Before joining MACPAC, Blom was an analyst in health care financing at the Congressional Research Service. Before that, Blom worked as a principal analyst at the Congressional Budget Office, estimating the federal budgetary effects of proposed legislation affecting the Medicaid program. Blom has also been an analyst for the Medicaid program in Wisconsin and for the U.S. Government Accountability Office. Blom holds a master of international public affairs from the University of Wisconsin, Madison, and a bachelor of arts in international studies and Spanish from the University of Wisconsin, Oshkosh.

Caroline Broder is the director of communications. Before joining MACPAC, Broder led strategic communications for a variety of health policy organizations and foundations, developing and implementing communications strategies to reach both the public and policymakers. Broder has extensive experience working with researchers across multiple disciplines to translate and communicate information for the public. Earlier positions include working as a reporter covering health and technology policy issues. Broder holds a bachelor of science in journalism from Ohio University.

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