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INSIGHTS

MACPAC Meeting on Increased FMAP Implementation and Medicare-Medicaid Plan Transition

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On September 19, 2025, the Medicaid and CHIP Advisory Commission (MACPAC) met for the second day of its September session, focusing on key takeaways from the implementation of the enhanced federal medical assistance percentage (FMAP) for home- and community-based services (HCBS) under the American Rescue Plan Act (ARPA), as well as issues related to the Medicare-Medicaid transition.

IMPLEMENTATION OF INCREASED FMAP FOR HCBS UNDER THE ARPA: KEY TAKEAWAYS

MACPAC staff reviewed how states used the temporary 10 percent FMAP increase authorized under the ARPA. Research found the enhanced match, available from April 2021 through March 2022, was intended to supplement—not supplant—state spending and required states to invest in activities that enhanced, expanded, or strengthened HCBS. Together, federal and state dollars generated an estimated $37 billion for reinvestment through the FMAP increase. CMS oversaw the initiative through guidance letters, required quarterly spending plans, and semi-annual progress reports. While the funds were initially set to expire in March 2024, spending deadlines were extended to March 2025, with about half of states receiving further extensions into 2026.

MACPAC staff reported that most states directed their funds toward HCBS workforce initiatives, including recruitment, retention, and training, with additional investments in quality improvement, reducing waiting lists, and cross-system partnerships. However, states faced significant challenges with timing, as they had only a short window to develop and submit spending plans, making robust stakeholder engagement and planning difficult. Administrative hurdles, such as hiring staff and making waiver or plan amendments, further constrained implementation. Evaluation was also limited, as the law did not require comprehensive assessments of funded activities, and states often lacked capacity, data, or time to measure outcomes. Another large concern was sustainability: although two-thirds of states included some plans to maintain activities beyond the funding period, only about one-third of workforce-related initiatives appear likely to be sustained. In many cases, funds were used for temporary relief or stopgap measures rather than long-term system improvements. The next steps include publishing an issue brief that summarizes the monitoring activities and the lessons learned to date.

MEDICARE-MEDICAID PLAN TRANSITION

MACPAC staff next outlined progress and challenges in shifting from the Financial Alignment Initiative

completed procurements and are set to transition to D-SNPs by January 1, 2026. States reported that while procurement was complex—often delayed by bid protests or misaligned state and Medicare Advantage timelines—they are largely confident in their ability to meet the transition. In terms of enrollment and IT changes, the transition entails moving from broker-based enrollment to a process in which the D-SNP handles Medicare enrollment while the state handles Medicaid. This shift introduces potential for timing mismatches, which states are addressing via system updates and coordination to avoid enrollment lags. Stakeholder engagement is also a focus, and states are actively communicating with beneficiaries, plans, and advocates. States are also developing guidance and limiting unnecessary notices to reduce confusion. MACPAC's next step is to continue monitoring how states manage these shifts to identifier systems, deployment of new policies, beneficiary communication, and operational readiness.

Commissioner discussion highlighted significant concerns about the transition from MMPs to integrated D-SNPs. Commissioners noted the daunting nature of the process for dual eligibles, raising questions about whether the integrity of D-SNPs will hold up and whether plans may push back against integration efforts. They emphasized the complexity of aligning CMS, Medicare, and Medicaid requirements, cautioning that this transition poses larger systemic challenges. Continuity of care also emerged as a key issue, with worries about how many beneficiaries may lose access to their providers or benefits, and how disruptive the shift might feel for enrollees accustomed to the current model. While some elements of the transition are still in flux, commissioners underscored the importance of maintaining a strong focus on consumer experience, tracking outcomes, and ensuring that both Medicaid and CHIP programs continue to play their critical roles in meeting the needs of vulnerable populations.

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