MACPAC Releases June 2025 Report to Congress

On June 11, the Medicaid and CHIP Payment and Access Commission (MACPAC) released their June 2025 Report to Congress, which included the following chapters:

- Access to Medications for Opioid Use Disorder in Medicaid,
- Understanding the Program of All-Inclusive Care for the Elderly, and
- Self-Direction for Home- and Community-Based Services.

The full report is available here.

MACPAC DISCUSSES CURRENT MEDICATIONS FOR OPIOID USE DISORDER, FEDERAL AND STATE INITIATIVES, BARRIERS TO ACCESS, AND UTILIZATION TRENDS

In this chapter, MACPAC examines access to medications for opioid use disorder (MOUD) within the scope of Medicaid, including existing MOUD options, recent state and federal policy initiatives, barriers and disparities regarding MOUD access, and MACPAC's plans for further research.

Medicaid and CHIP are key components in addressing opioid use disorder (OUD), covering nearly 40 percent of affected individuals aged 12-64 (roughly 1.9 million people according to 2022 data). Medicaid beneficiaries are twice as likely to have OUD when compared with the general population (54.6 per 100,000 vs. 27.9 per 100,000 in 2022), owing to lower incomes and other health-related risk factors (e.g. housing instability and elevated unemployment).

OUD is categorized as a chronic condition shaped by the complex interactions between opioids and the brain, genetics, and other environmental and social factors. MOUD, particularly methadone, buprenorphine, and naltrexone, are effective treatments to reduce illicit opioid use and overdose mortality. Use of MOUDs can also help reduce other associated socioeconomic costs and reliance on acute care services.

Medications for Opioid Use Disorder

Methadone is a full opioid agonist that binds to and activates the brain's opioid receptors. In addition to reducing cravings and suppressing withdrawal symptoms, it also limits or entirely blocks the effects of other opioids. It is taken orally on a daily basis and is dispensed only through certified opioid treatment programs (OTPs).

Buprenorphine is a partial agonist that helps control cravings and withdrawal symptoms. Compared with methadone, it has a lower risk profile, is more broadly accessible through pharmacies and OTPs, and is often combined with naloxone (used to reverse overdoses). Buprenorphine is available in oral and injectable forms in daily, weekly, or monthly formulations.

Naltrexone is an antagonist that blocks opioid receptors and prevents relapses by blocking the desired euphoria associated with opioid use. However, because of how naltrexone binds with opioid receptors, patients must undergo withdrawal and remain opioid-free or face life-threatening side effects. Research has shown it is least effective in reducing overdose risk of the three MOUDs discussed in this chapter. Naltrexone is administered orally or by injection, and because it is not a controlled substance, can be prescribed by any physician.

Despite all three of these medications being FDA-approved, states were not required to cover them until the 2018 Substance Use-Disorder Prevention that Prevents Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). This federal mandate compelled all states to cover any FDA-approved MOUD and any related counseling and behavioral therapies for five years beginning in FY 2020. Congress made this requirement permanent in 2024. However, three states and four territories applied for and received five-year exceptions to this policy, citing a lack of OTPs to provide methadone treatment.

Federal and State Initiatives

At both the federal and state levels, new policies and programs have created novel pathways to expand MOUD access over the last several years.

- **Provider Capacity Demonstrations:** As part of the SUPPORT Act, CMS funded planning grants in fifteen states to build provider networks and awarded five of these states additional funding for a three-year post planning process. All five of those states reported increases in access to Medicaid providers qualified to prescribe methadone and buprenorphine, but noted concerns about funding uncertainty and that the COVID-19 Public Health Emergency (PHE) had delayed or limited their efforts.

- **Section 1115 Demonstrations:** MACPAC interviewees cited the importance of Section 1115 demonstrations, where states can apply for and receive additional flexibility under federal law to spend Medicaid dollars in ways that are otherwise prohibited. 2017 and 2023 guidance from CMS allowed states to apply for funding to provide services for beneficiaries receiving substance use disorder (SUD) treatment in institutions for mental diseases (IMDs), and reentry support for justice-involved individuals, respectively. These demonstrations are now active in 37 and 19 states respectively, with a handful of additional applications for both types of programs pending.
- **State Plan Option for IMDs:** The SUPPORT Act also allowed states to cover withdrawal management or SUD treatment services under the state plan in IMDs. This authority was permanently extended in 2024, and as of 2023, two states utilize this to cover short-term SUD treatment.
- **Health Homes:** As of 2024, seven states have established health homes with federal assistance that integrate behavioral health and MOUD into long-term care services.
- **Additional Federal Prescription Flexibilities and Grant Funds:** Originally in response to the COVID-19 pandemic, the Substance Abuse and Mental Health Services Administration (SAHMSA) provided greater flexibility regarding take-home methadone doses for patients. In 2024, SAHMSA made these flexibilities permanent, but concerns persist regarding state-level payment methodologies that may discourage longer prescriptions. Additionally, the DEA codified buprenorphine prescription via telehealth during the COVID-19 PHE and further extended these provisions in 2025. The Consolidated Appropriations Act (2023) lowered the bar to prescribe buprenorphine for OUD. States have also leveraged funding from varied sources to extend MOUD access, build additional relevant infrastructure, and pay for services not traditionally covered by Medicaid (e.g. harm reduction or peer support programs).

Utilization Disparities and Barriers

As of 2022, 71 percent of Medicaid beneficiaries with OUD received MOUD, an 8 percent increase from 2017. However, a substantial gap remains, with nearly 30 percent of beneficiaries with OUD not receiving MOUD. MOUD utilization rates for patients with OUD vary widely, from 42 percent in Iowa to 84 percent in Vermont. MACPAC staff identified that access to MOUD remains a significant problem and is likely a major contributing factor to this discrepancy. As of 2022, 34 percent of U.S. counties had no

OTPs or buprenorphine providers, and over half of U.S. counties had no MOUD providers that accept Medicaid. White beneficiaries are also more likely to receive MOUD, while Black, Asian American, and Pacific Islander populations have lower rates of use.

A recent study by SAMHSA also reviewed publicly available information and could not find evidence that all Medicaid fee-for-service and managed care programs covered all forms of MOUD in every state. In two states, researchers were only able to positively identify coverage for methadone. SAMHSA notes this may be due to prior authorization requirements, lack of publicly available documentation, and other utilization management tools, and that all states (except those exempted due to provider shortages) cover all FDA-approved MOUD as part of their state plans. MACPAC staff added this lack of clarity may also impede providers seeking to prescribe MOUD.

MACPAC staff also discussed several barriers to access to MOUD, highlighting stigma and misinformation around MOUD, state-level zoning and prescribing restrictions, potential DEA scrutiny of large MOUD orders, and utilization management (including prior authorizations and prescription limits).

Despite recent policy efforts and declining overdose deaths, opioid mortality remains a significant issue. MACPAC plans to conduct further research on this subject, with a focus on access to MOUD.

MACPAC EXAMINES THE PACE PROGRAM AND SPOTLIGHTS CHALLENGES REGARDING ADMINISTRATION AND SERVICE UTILIZATION

In this chapter, MACPAC provides an overview of the Program of All-Inclusive Care for the Elderly (PACE), then examines how the model is designed, administered, and overseen by states and the federal government. It summarizes interview findings on eligibility and enrollment, provider application and procurement, service delivery, grievances and disenrollment, oversight, and payment.

PACE offers fully integrated Medicare and Medicaid coverage to individuals age 55 or older who require a nursing facility level of care (NFLOC) but can live safely in the community with the support of an interdisciplinary team of providers. PACE aims to delay or avoid institutional care and its significant associated costs, offering flexible coverage including transportation, meals, dental care, and more, without the usual Medicare/Medicaid service or cost-sharing limits. The program originally began as a demonstration in California, and after becoming permanent in 1997, enrolls over 83,00 individuals across 33 states and the District of Columbia as of April 2025. PACE organizations assume full financial responsibility for enrollees' care and in exchange, receive frailty-adjusted capitated per member per month payments by state Medicaid, federal Medicare, and beneficiary cost sharing. However, approximately 80 percent of beneficiaries are not subject to this cost sharing owing to their dual eligibility for Medicare and Medicaid. In FY 2023, total state and federal Medicaid spending on PACE programs was $3.9 billion, with MACPAC unable to determine total Medicare spending. Existing research has shown that PACE participants tend to have better outcomes than similar groups, including lower mortality and reduced nursing facility use.

To understand PACE design and administration, MACPAC interviewed state and federal officials, consumer advocates, and PACE organizations. While most agreed that PACE represents the most fully integrated care model for dually eligible individuals, they also identified challenges, particularly unclear oversight roles and lack of utilization data.

Eligibility and enrollment are often limited by outreach and referral challenges. Most enrollees learn about PACE through word-of-mouth or community sources, with states and providers facing advertising constraints. Since PACE participants can only receive care from PACE providers, community providers can be hesitant to refer individuals to PACE. Individuals looking to join PACE programs may also face lengthy and restrictive eligibility and enrollment processes. On the provider end, those looking to start a PACE program (or expand an existing one) face lengthy and resource-intensive processes involving both state and federal approvals.

Oversight of PACE is jointly managed by federal and state agencies. However, stakeholders described the oversight structure as fragmented, with unclear federal-state roles. Reporting on utilization and quality is inconsistent, and many states lack systems to track or assess data effectively. While CMS conducts annual audits and quarterly reviews, these focus on compliance, not performance outcomes. PACE organizations and states alike expressed frustration with CMS's inconsistent messaging and perceived micromanagement. Consumer advocates also called for stronger regulatory protections, such as specific beneficiary protections and clearer quality metrics.

States' primary oversight responsibilities include approving involuntary disenrollments, assessing eligibility, and handling external appeals. Some states conduct annual audits, check care plans, and review staff training and meeting documentation. However, overall state oversight capacity is limited, and quality review varies widely. Many states rely on participant and caregiver satisfaction surveys to assess quality, but these are limited in scope and may not reflect broader experiences among dually eligible populations.

Most states do not require Medicaid encounter data from PACE organizations. Tracking services provided by interdisciplinary team members is complex, and existing state systems are not designed for PACE's high-touch, individualized care model. Even when organizations can report data, states often do not request it. Organizational capacity also varies widely, and providers report that CMS data reporting demands are burdensome. Consumer advocates continue to call for better data collection and transparency, including service utilization, care transitions, and demographic breakdowns.

MACPAC identified widespread support among stakeholders for the development of national quality measures. Past CMS efforts were hindered by concerns about comparability due to small program size and diverse populations. Despite these concerns, states such as New York and the National PACE Association (NPA) are working on standardized quality measures to improve oversight and comparability across programs.

PACE operates on integrated, capitated payments from Medicaid and Medicare, and are generally based on expected costs of care in nursing facilities or home- and community-based services. States use a variety of methods to set capitation rates, often relying on third-party actuaries and fee-for-service or managed care data. California is unique in its use of utilization data from PACE organizations to develop experience-based rates. However, this method applies only to organizations that meet enrollment size thresholds. Many stakeholders expressed concerns about rate adequacy and transparency. CMS requires documentation of how rates are calculated and that they remain below what Medicaid would otherwise pay (AWOP), but it does not require actuarial soundness for PACE rates as it does for other managed care programs.

PACE enrollment, spending, and policy interest continue to grow. Stakeholders see it as an effective, comprehensive model for older adults with complex needs, despite its small footprint in the integrated care landscape. The Commission plans to conduct further research into PACE programs in the future.

MACPAC PROVIDES AN OVERVIEW OF SELF-DIRECTION IN MEDICAID HCBS, HIGHLIGHTS STATE FLEXIBILITIES AND ADMINISTRATIVE CHALLENGES

In this chapter, MACPAC examines how states implement self-direction in Medicaid home- and community-Based Services (HCBS), focusing on cross-agency administration, and persistent challenges related to role definition, oversight, and data limitations. Drawing on interviews with state officials, subject matter experts, and national advocates, the Commission highlights massive structural inconsistencies and the need for greater policy coherence.

Self-direction continues to expand nationally but remains deeply fragmented. All 50 states and the District of Columbia offer self-directed HCBS, with the goal of allowing beneficiaries to remain in their home (or a similar home-like setting) through the provision of long-term services and supports (LTSS). Over 1.5 million beneficiaries were enrolled in these services in 2023, a 23 percent increase from 2019.

States use a mix of Medicaid authorities to administer these services, including Section 1915(c) waivers, and state plans. However, states vary widely in eligible services, administrative authorities and included populations. Some states centralize administration within a Medicaid agency, while others distribute responsibilities across multiple departments covering aging, disability, and other services and supports. Additionally, some states contract with financial management services (FMS) agencies to handle payroll, taxes, and other administrative tasks for self-directed care. In some states, the beneficiary is the legal employer of their caregiver, while in others, the agency retains that role. There are a multitude of ongoing challenges associated with these varied approaches as states work to best support beneficiaries.

MACPAC found that states structure programs differently based on their goals, populations served, and existing agency frameworks. Some states divide responsibility across multiple departments, which can lead to inconsistent oversight and support. In some programs, the case managers and support brokers, for example, can have overlapping responsibilities.

Some states lack the data infrastructure to track self-directed care, and limited interoperability and inconsistent data practices continue to be a challenge for oversight and administration.

Family caregivers also play a role in self-directed programs by sometimes serving as paid providers. While this can help address workforce shortages and cultural alignment, it also raises concerns about oversight, accountability, and potential conflicts of interest. Some states limit caregiver hours or set guardrails to manage risks tied to informal caregiving, though enforcement varies. Their involvement supports access and cultural fitness but also raises concerns around labor compliance, overwork, and autonomy.

MACPAC stresses that the long-term success of self-direction depends on stronger infrastructure including clearer roles, standardized training, and better data for oversight and equity. While these programs offer demonstrable choice and flexibility, their impact relies on the success of supporting systems. The Commission plans to continue its research into self-directed HCBS to improve quality, support the workforce, and strengthen accountability.

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