



Medicaid Section 1115 Waivers for Substance Use Disorders: A Review

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A. Introduction

The United States continues to experience a public health crisis related to substance use disorders (SUD) and an overdose epidemic that has only been exacerbated by the COVID-19 pandemic. An estimated 20.4 million individuals (7.4% of the population) had a SUD in 2019, and preliminary studies show that this number likely increased as a result of the events of this past year.¹ Thanks to the Affordable Care Act (ACA), many states expanded coverage to low-income uninsured adults, which has transformed Medicaid into the largest payer of SUD services.² Despite this fact, and despite the fact that evidence-based treatment is available to reduce the effects of SUDs, most individuals with SUD (89.7%) are currently not receiving treatment.³

States have sought to remedy this situation by expanding coverage of SUD services for Medicaid beneficiaries and making services easier to access. States have used Medicaid's rehabilitation option, the home health state plan option, and Section 1915(i) to cover essential services.⁴ In addition, over thirty states have resorted to the use of Section 1115 waivers to introduce changes in conjunction with these broader coverage reforms. However, the legality of the use of Section 1115 waivers for these purposes, their effectiveness in improving access

¹ Substance Abuse and Mental Health Servs. Admin. (SAMHSA), *Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health* (2020), <https://store.samhsa.gov/product/key-substance-use-and-mental-health-indicators-in-the-united-states-results-from-the-2019-national-survey-on-drug-use-and-health/PEP20-07-01-001>; Nirmita Panchal et al., Kaiser Fam. Found., *The Implications for COVID-19 for Mental Health and Substance Use* (2021), <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>.

² SAMHSA, *Projections for Natural Expenditures for Treatment of Mental and Substance Use Disorders, 2010-2020* (2014), 31–34, <https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4883.pdf>. See also Julia Zur et al., Kaiser Fam. Found., *Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals* (2017), <https://files.kff.org/attachment/Issue-Brief-Medicoids-Role-in-Financing-Behavioral-Health-Services-for-Low-Income-Individuals>. For more background information on coverage of SUD services in Medicaid, see Héctor Hernández-Delgado & Corey S. Davis, Nat'l Health Law Prog., *Medicaid & the ACA: Vital Tools in Addressing the Opioid Epidemic* (2017), <https://healthlaw.org/resource/medicaid-the-aca-vital-tools-in-addressing-the-opioid-epidemic/>.

³ SAMHSA, *supra* note 1, at 52.

⁴ MACPAC, *Recovery Support Services for Medicaid Beneficiaries with a Substance Use Disorder* (2019), <https://www.macpac.gov/wp-content/uploads/2019/07/Recovery-Support-Services-for-Medicaid-Beneficiaries-with-a-Substance-Use-Disorder.pdf>.

to care for SUD services, and the need to use them in place of state plan amendments (SPAs) is questionable.

After summarizing the SUD standard of care and Medicaid coverage of SUD services in general, this paper discusses the legality and problematic use of Section 1115 waivers to obtain federal funding for SUD services in certain settings. The paper then discusses the findings from an analysis of the special terms and conditions of all approved Section 1115 SUD waivers, summarizing what they purport to do and how provisions have changed since the adoption of the first waiver in 2015. Finally, we offer an alternative to this misuse of Section 1115 SUD waivers, with recommendations that the federal government can use to encourage states to make permanent and substantial improvements to Medicaid coverage of SUD services via authority that states already possess.⁵

B. Overview of SUD Standard of Care

The best practices for SUD treatment revolve around medication-assisted treatment (MAT), an evidence-based and clinically driven practice for this condition.⁶ MAT is the use of medication to treat SUD, often used in conjunction with behavioral therapy, and is particularly effective in the treatment of opioid use disorders (OUD).⁷ Different medications can be used for MAT and

⁵ This analysis is limited in scope. It focuses on the waivers' special terms and conditions and the services provided and delivery and provider availability reforms approved by the Centers for Medicare and Medicaid Services (CMS) as part of these terms and conditions. Our review did not extend to coverage of SUD services under Medicaid state plans nor did we review periodic evaluations of approved Section 1115 waivers. As such, the conclusions that we reached here only apply to the language of the special terms and conditions or, when applicable, waiver proposals. It is plausible, for example, that some states may have committed to implementing certain policies through 1115 waivers, but are failing to comply with the requirements in practice. Similarly, a state may be providing robust SUD coverage under the state plan, which may not be captured in this analysis if such state plan coverage is not discussed in the waiver special terms and conditions.

⁶ SAMHSA, *Medication-Assisted Treatment (MAT)*, <https://www.samhsa.gov/medication-assisted-treatment> (last visited April 7, 2021).

⁷ Tanay Maiti et al., *An Overview on Medication-Assisted Treatment (MAT) for Opioid Dependence*, 16 J. OPIOID MGMT. 2, 141–149 (2020); Jennifer L. Koehl et al., *Medications for Management of Opioid Use Disorder*, 76 AM. J. HEALTH SYS. PHARM. 15, 1097–1103 (2019); Corey S. Davis, et al., Nat'l Health Law Prog., *Medication-Assisted Treatment for Opioid Use Disorder: The Gold Standard* (2018), <https://healthlaw.org/resource/medication-assisted-treatment-for-opioid-use-disorder-the-gold-standard>; The Pew Charitable Trust, *Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder* (Nov. 22, 2016)

each medication has its own guidelines for use.⁸ Methadone, buprenorphine, and naltrexone are the three medications that have been approved by the Food and Drug Administration (FDA) for use in MAT for treatment of SUD and OUD.⁹ Methadone and buprenorphine work by affecting opioid receptors in the brain, which stops the person taking them from experiencing painful withdrawal symptoms from ceasing opioid use.¹⁰ Naltrexone works as an opioid antagonist that blocks the effects of opioids by binding and blocking opioid receptors.

MAT is highly effective in reducing overdose deaths, reducing the risk of relapse, reducing the rate of engaging in risky activities, and reducing costs of SUD treatments.¹¹ It is also highly effective in increasing the likelihood that a person will remain in treatment, thus reducing overdose deaths.¹² While all three medications may be effective depending on the circumstances, buprenorphine and methadone have more and stronger evidence supporting their effectiveness. It is essential to increase the availability of both buprenorphine and methadone to improve the conditions of individuals with SUD.¹³

According to the American Society of Addiction Medicine (ASAM) National Practice Guidelines for the Use of Medications in the Treatment of Addiction Involving Opioid Use, clinical recommendations include: assessment and diagnosis of opioid use disorder through a medical history review; screening for comorbid disorders like psychiatric disorders; physical

<http://www.pewtrusts.org/en/research-and-analysis/factsheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-usedisorder>.

⁸ Kyle Kampman and Margaret Jarvis, *National Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use*, 9 J. ADDICT. MED. 358 (2015), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4605275/>.

⁹ SAMHSA, *Medication-Assisted Treatment (MAT)*, <https://www.samhsa.gov/medication-assisted-treatment> (last visited Apr. 9, 2021)

¹⁰ SAMHSA, *Methadone*, <https://www.samhsa.gov/medication-assisted-treatment/treatment/methadone> (last visited Mar. 11, 2021); see also SAMHSA, *Buprenorphine*, <https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/buprenorphine> (last visited Mar. 11, 2021).

¹¹ National Institute on Drug Abuse, *Effective Treatments for Opioid Addiction* <https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction> (last visited April 9, 2021)

¹² SAMHSA, *Medication-Assisted Treatment (MAT)*, <https://www.samhsa.gov/medication-assisted-treatment> (last visited April 7, 2021).

¹³ Am. Soc’y of Addiction Med. (ASAM), *Advancing Access to Addiction Medications* (2013), https://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final.

examination; and diagnosis and referral to appropriate services.¹⁴ Clinicians may then refer to the ASAM Criteria for placement for treatment. Placement differs from services and coverage of services as discussed in section C. The ASAM criteria for placement includes levels of care that reflect a continuum of care. This continuum of care is marked by increase in intensity of placements, meaning that a person may receive treatment in settings from outpatient care all the way up to an inpatient hospital setting, with varying levels of medical supervision required.¹⁵

MAT is considered standard best practice in treating SUDs and in some instances, can be coupled with other services and supports, including, but not limited to, individual and group counseling, peer support, case management, permanent supported housing, individual placement and support employment services, and other recovery services.¹⁶ All of these services can be covered by Medicaid.¹⁷ However, the effectiveness of MAT is not dependent on the inclusion of other services and MAT initiation should not be delayed if an individual declines other supports. These services and how they are covered in the Medicaid program are further covered in Section C.

ASAM has also developed criteria for placement of patients receiving withdrawal management or detoxification services. Withdrawal management is defined as the process of withdrawing a person from psychoactive substances in a safe and effective manner as they experience physical and mental effects of ending substance use.¹⁸ The ASAM criteria is used to define withdrawal management levels of care. These levels of care are used for adult and adolescent treatment plans but treatment and care plans should include all medically necessary services covered by Medicaid. The criteria relate to the intensity of care needed for the person experiencing withdrawal, and range from ambulatory care all the way up to intensive

¹⁴ Kampman and Jarvis, *supra* note 8.

¹⁵ ASAM, *About the ASAM Criteria*, <https://www.asam.org/asam-criteria/about> (last visited Mar. 11, 2021).

¹⁶ *National Institute on Drug Abuse, Effective Treatments for Opioid Addiction* <https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction> (last visited April 9, 2021).

¹⁷ See 42 U.S.C. §§ 1396d(a)(19); 1396n(g)(2); (case management services); 1396d(a)(13)(C) (rehabilitative services); 1396d(29) (medication assisted treatment, including “with respect to the provision of such drugs and biological products, counseling services and behavioral therapy.”); 1396d(a)(6) (any other remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.”).

¹⁸ ASAM, *The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update* (2020), Pg 6 & Part 3 https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2 (last visiting Mar. 11, 2021).

withdrawal management in an inpatient setting.¹⁹ These withdrawal management criteria were originally developed for alcohol withdrawal specifically, but have been adopted by states for use in other withdrawal situations, including for treatment of OUD.²⁰

C. Medicaid Coverage of SUD Services and Placement Levels

1. Coverage of SUD Services under Traditional Medicaid and Medicaid Expansion

Covered SUD services vary considerably between states. Most SUD services are coverable by Medicaid under mandatory benefits categories and through several optional benefit categories in traditional Medicaid programs, and as part of essential health benefits (EHB) categories in Medicaid expansion states that have not aligned alternative benefit plan (ABP) benefits with traditional Medicaid.²¹ Additional Medicaid beneficiaries with SUD gained coverage pursuant to the ACA's Medicaid expansion.²² The ACA requires states to provide coverage to expansion populations through ABPs, which must, at a minimum, provide coverage for at least the ten categories of EHBs, including mental health and SUD services and prescription drug services, under which most SUD services fall.

Most expansion states, however, have aligned their ABP coverage for the expansion population with the state's traditional Medicaid benefits. Under traditional Medicaid programs, states may provide SUD coverage under several mandatory or optional benefit categories. For example, states may cover SUD provider visits under the mandatory physicians benefit category.²³

¹⁹ ASAM, *The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management* (2020), <https://www.asam.org/docs/default-source/quality-science/awg-3-20-20.pdf>.

²⁰ For more detailed information on the ASAM placement and withdrawal management criteria, see Appendix 2 and Appendix 3.

²¹ See Michelle Lilienfeld, *Health Advocate: Essential Health Benefits Overview*, Nat'l Health Law Prog. (Aug. 12, 2015), <https://healthlaw.org/resource/health-advocate-essential-health-benefits-overview/>.

²² See U.S. Dep't of Health & Hum. Servs., Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* 6-7, 6-23 (Nov. 2016), <https://store.samhsa.gov/product/Facing-Addiction-in-America-The-Surgeon-General-s-Report-on-Alcohol-Drugs-and-Health-Full-Report/SMA16-4991>.

²³ 42 U.S.C. § 1396a(10)(A); 42 U.S.C. §§ 1396d(a)(2) (outpatient hospital services), (6) ("medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of the their practice as defined by State law", (13)(C) ("any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;").

Similarly, some states cover services such as counseling and behavioral therapies under the mandatory category of outpatient hospital services (if the setting is applicable) and others cover different SUD services under the optional rehabilitative services category. States may also offer targeted case management services for beneficiaries with SUD under the optional case management benefit. The cost of the medications used for MAT is typically covered under the pharmacy benefit optional benefits category, which all states cover.²⁴

In addition, coverage of medications used for MAT is mandatory under section 1006(b) of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) for the period of October 1, 2020 through September 30, 2025, as are “counseling services and behavioral health services” provided in conjunction with medications for substance and opioid use disorders.²⁵ However, since methadone for OUD is typically not available on an outpatient basis and, under federal law, must be accessed through opioid treatment programs (OTPs) and since buprenorphine is often also administered in an office setting, states usually need to provide coverage for other provider services in conjunction with the medication.²⁶ As discussed in more detail below, the Medicaid program’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit requires state Medicaid programs to provide youth with screenings, diagnostic services, and all health care services that are medically necessary “to correct and ameliorate defects, physical and mental illnesses, and conditions discovered by [a] screening service,” regardless of whether these services are covered under the Medicaid State Plan.²⁷

While prescription drugs and outpatient services are broadly covered, coverage for residential and inpatient SUD treatment is generally more limited in Medicaid. In general, federal Medicaid funds are only available to pay for services in residential and inpatient settings that do not fall into the definition of Institutions for Mental Diseases (IMD).

²⁴ 42 U.S.C. §§ 1396d(a)(12), 1396r-8.

²⁵ 42 U.S.C. §§ 1396d(a)(29); 1396d(ee). *See also*, CMS, Dear State Health Official Letter (Dec. 30, 2020) (SHO # 20-005), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf>.

²⁶ For background information on the federal limitation around provision of buprenorphine and methadone maintenance treatment, *see* U.S. Gov’t Acct. Off. (GAO), *Opioid Addiction: Laws, Regulations, and Other Factors can Affect Medication-Assisted Treatment Access* (2016), <https://www.gao.gov/assets/gao-16-833.pdf>.

²⁷ 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r); CMS, *Early and Periodic Screening, Diagnostic, and Treatment*, <https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html> (last visited Mar. 11, 2021).

2. The Institutions for Mental Diseases Exclusion, Exceptions to the Exclusion, and Use of Medicaid Section 1115 to Waive the Exclusion

The Medicaid Act prohibits federal financial participation (FFP) for services provided to beneficiaries residing in an IMD. An IMD is a “hospital, nursing facility, or other institution of more than sixteen beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases including medical attention, nursing care, and related services.”²⁸ Section 1396d(a)(30)(B), known as the “IMD exclusion,” generally prohibits Medicaid payment for any services provided to an individual under age sixty-five who is a patient in an IMD, regardless of whether the services are provided inside or outside of the IMD.

Over the years, several statutory exceptions to the IMD exclusion rule have been established. Section 1905(a) contains two long-standing exceptions to the exclusion. First, the exclusion only applies to individuals under age 65. Thus, inpatient hospital services, nursing facility services, and intermediate care facility services for individuals age sixty-five and older in IMDs can be reimbursed. Second, inpatient psychiatric hospital services for individuals under age twenty-one furnished by a psychiatric hospital, a psychiatric unit within a general hospital, or other inpatient setting that meets requirements established by the Secretary of Health and Human Services may be paid for through FFP. This is commonly referred to as the ‘psych under twenty-one’ benefit and it is an optional Medicaid benefit that gives states the ability to cover SUD treatment for youth under twenty-one in inpatient and residential settings that may have more than sixteen beds.²⁹ Third, states may make payments to Managed Care Organizations (MCOs) or Prepaid Inpatient Health Plans (PIHPs) for short-term stays of up to 15 days per month for enrollees aged twenty-one to sixty-four receiving inpatient psychiatric or substance use disorder treatment at a hospital or sub-acute facility that would otherwise qualify as an IMD.³⁰

²⁸ 42 U.S.C. § 1396d(i).

²⁹ For more information on the “psych under twenty-one benefit” and its interplay with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement, see Héctor Hernández-Delgado & Kim Lewis, Nat’l Health Law Prog., *Fact Sheet: Medicaid Coverage of Inpatient Psychiatric Treatment for Individuals Under 21* (2018), <https://healthlaw.org/resource/medicaid-coverage-of-inpatient-psychiatric-treatment-for-individuals-under-21/>.

³⁰ 42 U.S.C. § 1396b(m)(7). This provision ensures FFP is available as was intended under existing 2016 HHS regulations, which in turn codified a long-standing policy regarding “in lieu of” services. A state may pay an MCO for services in an IMD as long as the state ensures that services being provided in the IMD are medically appropriate and a cost-effective substitute for a covered service under the state plan; the enrollee is not required to use the alternative

In addition to these exceptions, Congress recently enacted an additional time limited exception to the IMD exclusion. Passed in 2018, the SUPPORT Act includes a state plan option to cover services in an IMD for people with at least one SUD.³¹ This option is available to states from 2019 to 2023, and allows states to use federal Medicaid funding for services provided to beneficiaries residing in IMDs when such services are rendered for not more than thirty days during a one-year period.³² States adopting the option must comply with several important requirements. First, they must offer the full continuum of SUD care, including early interventions for those at risk of developing a SUD, outpatient services, intensive outpatient services, and partial hospitalization.³³ Second, states must ensure that beneficiaries' placement in an IMD allows for successful transition to the community; that beneficiaries in IMDs have access to the lowest placement level necessary; and that IMDs are able to provide or refer patients to care at such low level of care.³⁴ Finally, states must ensure that IMDs offer at least two forms of MAT on site, including at least one buprenorphine product.³⁵

Instead of using the several above-described legislative exceptions to the IMD exclusion, many states have recently, and problematically, relied on Medicaid Section 1115 demonstration projects to obtain FFP for services provided in IMDs. Section 1115 of the Social Security Act allows the U.S. Department of Health and Human Services (HHS) to waive some requirements of the Medicaid Act, allowing states to test novel approaches to improving medical assistance for low-income individuals and to receive FFP for costs of these waiver projects that would otherwise not be allowable. The provision gives the Secretary of HHS discretion to grant a waiver under limited circumstances. In order to be approved under Section 1115, a proposal must (1) propose an "experiment[], pilot, or demonstration," (2) waive compliance of requirements contained within 42 U.S.C. § 1396a of the Medicaid Act, (3) be likely, in the opinion of the Secretary, to promote the objectives of the Medicaid Act, and (4) be approved only "to the extent and for the period necessary" to carry out the experiment.³⁶

Under recent administrations, the Centers for Medicare and Medicaid Services (CMS) has invited and encouraged states to apply for SUD- and mental health-related Section 1115 waivers. In 2015, the Obama Administration issued State Medicaid Director Letter 15-003 in

service; and the approved services are authorized and identified in the managed care contract, and offered to enrollees at the option of the MCO. 42 C.F.R. §§ 438.3(e)(2)(i-iii); 438.6.

³¹ 42 U.S.C. § 1396n(l).

³² *Id.* at (1)–(2).

³³ *Id.* at (4)(C).

³⁴ *Id.* at (4)(D).

³⁵ *Id.* at (7)(C)(ii).

³⁶ 42 U.S.C. § 1315(a).

which it invited states to apply for Section 1115 projects to receive Medicaid funding for SUD services, including in IMD settings.³⁷ Similarly, CMS under the Trump Administration provided multiple opportunities for states to seek IMD funding through 1115 projects.³⁸ While both letters encouraged states to ask for FFP for IMDs via Section 1115 waivers, the letter issued during the Obama administration placed significant emphasis on the need to implement comprehensive and sweeping reforms of the SUD treatment protocol in conjunction with the use of IMDs.

While HHS has granted waivers allowing some states to receive FFP for services provided in IMDs, doing so is illegal under the standards for a Section 1115 waiver. First, because the IMD exclusion is found at 42 U.S.C. § 1396d(a)(30)(B) and 42 U.S.C. § 1396(i), the Secretary does not have authority to waive the IMD exclusion. The Secretary can only waive provisions of 42 U.S.C. § 1396a. CMS has justified these waivers by allowing states to obtain FFP for services within IMDs by using so-called “expenditure authority.” Once the Secretary has acted under Section 1115(a)(1) to waive compliance with designated provisions in Section 1396a, Section 1115(a)(2) provides that the costs of “such project” are “regarded as expenditures under the State plan” and, thus, paid for under the same statutory formula that applies for a state’s expenditures under its State plan. However, Section 1115(a)(2) does not create an independent “expenditure authority” for the Secretary to allow a state to ignore provisions of the Medicaid Act outside of section 1396a or to rewrite the provisions in section 1396a or any other provision outside of section 1396a. To the contrary, it is a “clean-up” provision that

³⁷ CMS, Dear State Medicaid Director Letter (July 27, 2015) (SMD # 15-003), <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/SMD15003.pdf> (“While services provided to individuals residing in IMDs are excluded as medical assistance under a state plan, states can request authority for federal financial participation (FFP) for these expenditures if their proposal for a section 1115 demonstration project meets the programmatic expectations described below.”); *id.* at 12 (“To the extent that a demonstration initiative is consistent with the expectations for a transformed SUD treatment system, CMS would specifically allow FFP for costs not otherwise matchable to provide coverage for services furnished to individuals residing in IMDs for short-term acute SUD treatment”).

³⁸ CMS, Dear State Medicaid Director Letter (Nov. 1, 2017) (SMD # 17-003), <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd17003.pdf> (“Through this new section 1115 initiative, states will have an opportunity to receive federal financial participation (FFP) for the continuum of services to treat addiction to opioids or other substances, including services provided to Medicaid enrollees residing in residential treatment facilities.”); CMS, Dear State Medicaid Director Letter (Nov. 13, 2018) (SMD # 18-011), <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf> (“through these demonstrations, states will focus on demonstrating improved care for individuals with serious mental health conditions in inpatient or residential settings that qualify as IMDs as well as through improvements to community-based mental health care.”).

merely provides the authorization necessary for federal reimbursement of expenditures for a project that has been approved under section 1115(a)(1).

Second, Section 1115 authority only allows HHS to waive requirements for experiments, where states are testing, in a time-limited manner, novel approaches to improving medical assistance for low-income individuals. This means a Section 1115 project waiver request must propose a genuine experiment of some kind, seeking to test out new ideas and ways of addressing problems faced by enrollees. The projects we reviewed for this paper fail to specify an experiment. Most projects include general statements about increased availability of SUD services in IMDs and how covering services in these settings will help states fight the ongoing opioid overdose epidemic. However, these general statements are not enough to satisfy the experimental requirements of Section 1115, as states should be explicitly making the connection between an experiment and measurable outcomes from the experiment.³⁹

Third, Section 1115 only allows approvals to the extent and for the period necessary to carry out the experiment.⁴⁰ As noted above, there are at least four statutory exceptions to the IMD exclusion that states can use to obtain FFP for services in IMDs. Congress did not enact Section 1115 to allow states to make long-term policy changes that circumvent express statutory requirements. Yet as detailed below in Section D, CMS is permitting many states to do just this.

3. EPSDT and SUD Treatment for Youth

The Medicaid EPSDT benefit provides comprehensive and preventive health services for children and youth under age twenty-one who are enrolled in Medicaid.⁴¹ Pursuant to EPSDT, states must provide youth with periodic screenings, diagnostic services, and all health care services that are medically necessary “to correct and ameliorate defects, physical and mental illnesses, and conditions discovered by [a] screening service,” regardless of whether these

³⁹ For more information about NHeLP’s legal and policy position regarding the IMD exclusion, see Jennifer Lav, Nat’l Health Law Prog., *Policy Implications of Repealing the IMD Exclusion* (2018), <https://healthlaw.org/resource/policy-implications-of-repealing-the-imd-exclusion/>.

⁴⁰ 42 U.S.C. § 1315(a).

⁴¹ 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r); CMS, *Early and Periodic Screening, Diagnostic, and Treatment*, <https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html> (last visited Mar. 11, 2021).

services are covered under the Medicaid State Plan for adults.⁴² This mandate extends to services necessary to prevent or treat a mental health or substance use condition.⁴³

The EPSDT benefit's requirement for screening coverage is key to identifying and treating children with SUDs. The National Institute on Drug Abuse has emphasized the importance of screening for SUD in young people, expressing that "adolescent substance use needs to be identified and addressed as soon as possible."⁴⁴ The practice of Screening, Brief Intervention, and Referral to Treatment (SBIRT) is considered the standard of care for screening of youth for SUD. The American Academy of Pediatrics has stated that, because adolescents are at high risk of experiencing substance use-related acute and chronic health conditions, they are the age group likely to derive the most benefit from regular screening and, if necessary, implementation of the appropriate intervention based on their experiences.⁴⁵

MAT with the medication buprenorphine or methadone, the gold standard for treating adults with SUD, is also recommended by the American Academy of Pediatrics for adolescents and young adults, although neither medication has been approved by the FDA for minors under 16.⁴⁶ However, recommended treatment for youth with SUD differs from adult treatment in that significantly more emphasis is placed on behavioral and family-based interventions.⁴⁷ Additional supports--such as education, recreational and social activities, employment services, and housing assistance--are important tools in reducing the harms associated with SUD among youth.⁴⁸ EPSDT includes coverage for case management and recovery services which prepare an individual to successfully seek and access education, housing, and employment; however, such expenses themselves are not covered.

⁴² 42 U.S.C. § 1396d(r)(5); *see also* CMS, *EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (2014), https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf.

⁴³ *Id.*

⁴⁴ Nat'l Inst. on Drug Abuse (NIDA), *Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide* (2014), https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/podata_1_17_14.pdf.

⁴⁵ Am. Acad. of Pediatrics (AAP) Comm. on Substance Use and Prevention, *Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatricians*, 128 PEDIATRICS 1330 (2011), <http://pediatrics.aappublications.org/content/pediatrics/early/2011/10/26/peds.2011-1754.full.pdf>.

⁴⁶ *Id.*

⁴⁷ *See, e.g.*, NIDA, *supra* note 44.

⁴⁸ Nat'l Ass'n of State Alcohol and Drug Abuse Dirs., Inc. (NASADAD), *State Adolescent Substance Use Disorder Treatment and Recovery Practice Guide* (2014), <http://nasadad.org/wp-content/uploads/2014/09/State-Adolescent-Substance-Use-Disorder-Treatment-and-Recovery-Practice-Guide-9-24-14.pdf>.

CMS has issued three bulletins on states' obligations with regards to screening, prevention, and treatment of SUD under the EPSDT benefit.⁴⁹ These bulletins clarify that states should provide coverage for many recommended services, including peer supports, MAT, family therapy, and parent/caregiver support. Importantly, the waivers reviewed and discussed in this paper in no way change or diminish the states' obligations under EPSDT.

D. Review of Section 1115 SUD Waivers

Since 2015, thirty-five states have submitted requests for Section 1115 Medicaid projects related to SUD. CMS has approved thirty-one of these requests, while the remaining four requests are currently pending approval.⁵⁰ We conducted a review of the terms and conditions of all approved waivers, as well as a review of the proposals for the four pending requests to identify patterns in four main areas: IMD exclusion and SUD services; provisions specific to children and youth; provider availability and delivery system reforms; and access to the SUD continuum of care with particular emphasis on community-based services provisions.⁵¹

1. IMD Exclusion and SUD Services

All of the SUD-specific Section 1115 projects reviewed had one component in common: they all sought or are seeking to waive the IMD exclusion, sometimes by extending coverage for otherwise covered services to situations when the services are provided in IMDs, and other times by adopting coverage for services that were not previously covered and making beneficiaries in IMDs eligible for those services. In fact, the one consistent request in every Section 1115 project proposal was a request to waive the IMD exclusion.⁵²

⁴⁹ CMCS, *Prevention and Early Identification of Mental Health and Substance Use Conditions* (Mar. 27, 2013), <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf>; CMCS & SAMHSA, *Coverage of Behavioral Health Services for Youth with Substance Use Disorders* (Jan. 26, 2015), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-26-2015.pdf>; CMS, *Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools* (July 1, 2019), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib20190701.pdf>.

⁵⁰ Requests pending approval as of March 5, 2021 are from Arizona, Missouri, Oregon, and Tennessee.

⁵¹ Appendix 1 includes a complete list and summary of all thirty-five waivers and corresponding links to the waivers' special terms and conditions or proposals.

⁵² Several states, particularly those that received waiver approval under the Obama administration, have also sought to waive other provisions in order to facilitate larger reforms.

When states ask to waive the IMD exclusion states request FFP for particular services to be provided in facilities that meet the definition of IMDs. In many instances, states already cover those services through the state plan. The state's covered services are usually described in a table summarizing the state's Medicaid SUD benefits, placement level coverage, and corresponding authority (whether through state plan, Section 1115, or any other legal authority).⁵³ Thus, the function of the waiver is to permit states to collect FFP for providing such services when the services are provided in IMD settings. For example, according to the Illinois 1115 waiver, Illinois's Medicaid state plan covers some residential SUD services (outside of IMDs), medically-supervised withdrawal management, and MAT.⁵⁴ In 2018, Illinois received 1115 waiver approval to cover all of these services when provided in an IMD setting.⁵⁵ Our review demonstrates that the vast majority of states with Section 1115 SUD projects (thirty) have sought waivers to allow the state to claim FFP to pay for SUD services, already available outside of an IMD and covered under the state plan, when provided for beneficiaries in IMDs. In fact, an increasing number of states (twenty) have relied on Section 1115 SUD waivers exclusively for this purpose.

Eleven states have received Section 1115 SUD waivers to expand coverage of certain services not otherwise covered through their state plans. In ten of these states, coverage of some or all of these additional services is limited to services that are rendered to beneficiaries in IMDs. For example, Alaska's state plan only provides for Medicaid coverage of MAT, outpatient SUD

For example, California, North Carolina, New Jersey, and Vermont waived the requirement that services be available for all beneficiaries regardless of where they reside in the state. By waiving this statewideness requirement, California limits access to SUD waiver services to residents of participating counties, which must first receive approval from the state and from CMS to implement the waiver services in a manner consistent with the waiver's terms and conditions. Moreover, several states, such as California, Kansas, New Mexico, North Carolina, and Virginia also waived freedom of choice requirements. The freedom of choice requirement mandates that beneficiaries be allowed to access the provider of their choice. Instead, these states restrict provision of SUD waiver services to a limited number of providers authorized by the state. In theory, such a waiver allows states to monitor the quality of care provided as well as compliance with waiver requirements. However, none of the proposals or special terms and conditions reviewed actually spelled out a measurable experiment other than generally stating that beneficiaries with SUD need access to these services and placement levels.

⁵³ See Appendix 5 for an example of these tables.

⁵⁴ CMS, Special Terms and Conditions for Illinois Behavioral Health Transformation Section 1115 Demonstration 9 (Aug. 16, 2018), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/il/il-behave-health-transform-ca.pdf>.

⁵⁵ *Id.*

services, and early intervention services.⁵⁶ Through its Section 1115 SUD waiver, however, the State covers various other services (opioid treatment, intensive outpatient, partial hospitalization, residential treatment, ambulatory withdrawal, among others) specifically for beneficiaries while residing in IMDs.⁵⁷ Similarly, Illinois's Section 1115 waiver authorizes coverage of the following services not covered under the state plan for individuals while receiving care in IMDs: clinically-managed withdrawal management, case management, and peer recovery support services.⁵⁸ Similarly, Rhode Island's Section 1115 waiver covers peer recovery support services only for beneficiaries while in IMDs.⁵⁹

Finally, five waivers include coverage of additional SUD services not contemplated in the state plan, regardless of the settings in which they are provided. However, when CMS has allowed states to do this, the agency has often used Section 1115 authority to implement other restrictions or waive Medicaid protections, such as statewideness or freedom of choice. These restrictions and waivers of Medicaid protections ultimately act as barriers to comprehensive access to SUD services. Instead, these additional SUD services could (and should) have been expanded outside of a Section 1115 project through the use of SPAs.

California, the first state approved for a Section 1115 SUD waiver, is a prime example of a state that used an 1115 waiver to expand services that should have been expanded via a SPA. The State, through its state plan, covers certain SUD services, such as perinatal residential services outside of IMDs, methadone maintenance treatment at narcotic treatment programs (NTPs), intensive outpatient treatment, outpatient drug free treatment, naltrexone treatment services, and prescription drug coverage for buprenorphine, methadone, and naltrexone.⁶⁰ While the IMD waiver is a central component of the demonstration, California also expanded coverage for all the following benefits regardless of the delivery setting: buprenorphine

⁵⁶ CMS, Special Terms and Conditions for Alaska Substance Use Disorder Treatment and Alaska Behavioral Health Program Section 1115 Demonstration 28-29 (Sept. 3, 2019), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/ak-behavioral-health-demo-ca.pdf>.

⁵⁷ *Id.* It is unclear why Illinois requested permission for federal funding for outpatient services (such as ambulatory withdrawal services) for beneficiaries residing in IMDs, considering that beneficiaries with SUD receiving residential services should not need additional outpatient services outside of the facility as long as the facility is in fact providing evidence-based and effective care.

⁵⁸ CMS, *supra* note 54, at 9.

⁵⁹ CMS, Special Terms and Conditions for Rhode Island Comprehensive Section 1115 Demonstration 58-59 (Dec. 20, 2018), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/Comprehensive-Demonstration/ri-global-consumer-choice-compact-cms-ext-request-appvl-12202018.pdf>.

⁶⁰ CAL. CODE REGS. tit. 22, § 51341.1(d)(1-6).

maintenance treatment services at NTPs; withdrawal management; recovery services; case management; physician consultation; partial hospitalization; and ordering, prescribing, administering, and monitoring of MAT.⁶¹ However, when doing so, California also requested as part of the Section 1115 request a waiver of “statewideness.” Therefore, these are not available throughout the State, as counties have the option to elect to opt-in to the waiver in order for beneficiaries to be able to receive them.

Similarly, West Virginia used Section 1115 authority to provide access to methadone maintenance treatment in OTPs and peer support services throughout the State.⁶² West Virginia could have expanded these services through a SPA, but the State elected to ask CMS to use so-called “expenditure authority” instead. The District of Columbia also added coverage for comprehensive psychiatric emergency programs; mobile crisis intervention services; and supported employment services and these services are available for all beneficiaries statewide regardless of whether they are receiving services at an IMD.⁶³ Notably, CMS approved these services only for two years and required the District of Columbia to submit a SPA for coverage beyond those two years.

Table 1 categorizes all approved waivers by the type of services covered. Figure 1 shows the number of each category of waivers approved each year from 2015 to 2020. As the figure shows, the number of approved waivers that limit the availability of SUD services to beneficiaries in IMDs has consistently increased, whereas the number of states adding services, either for beneficiaries in IMDs or regardless of setting, has decreased in the past few years. This table does not account for other limitations on services imposed through Section 1115. For example, the fact that a state is listed under the category of “states adding SUD services regardless of delivery setting or placement level” is not indicative that services are available to all Medicaid beneficiaries, as the state may be waiving statewideness.

⁶¹ CMS, Special Terms and Conditions for California Bridge to Reform Section 1115 Demonstration 123-124 (Aug. 13, 2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/Bridge-to-Health-Reform/ca-bridge-to-health-reform-2015-cms-amend-appvl-08132015.pdf>.

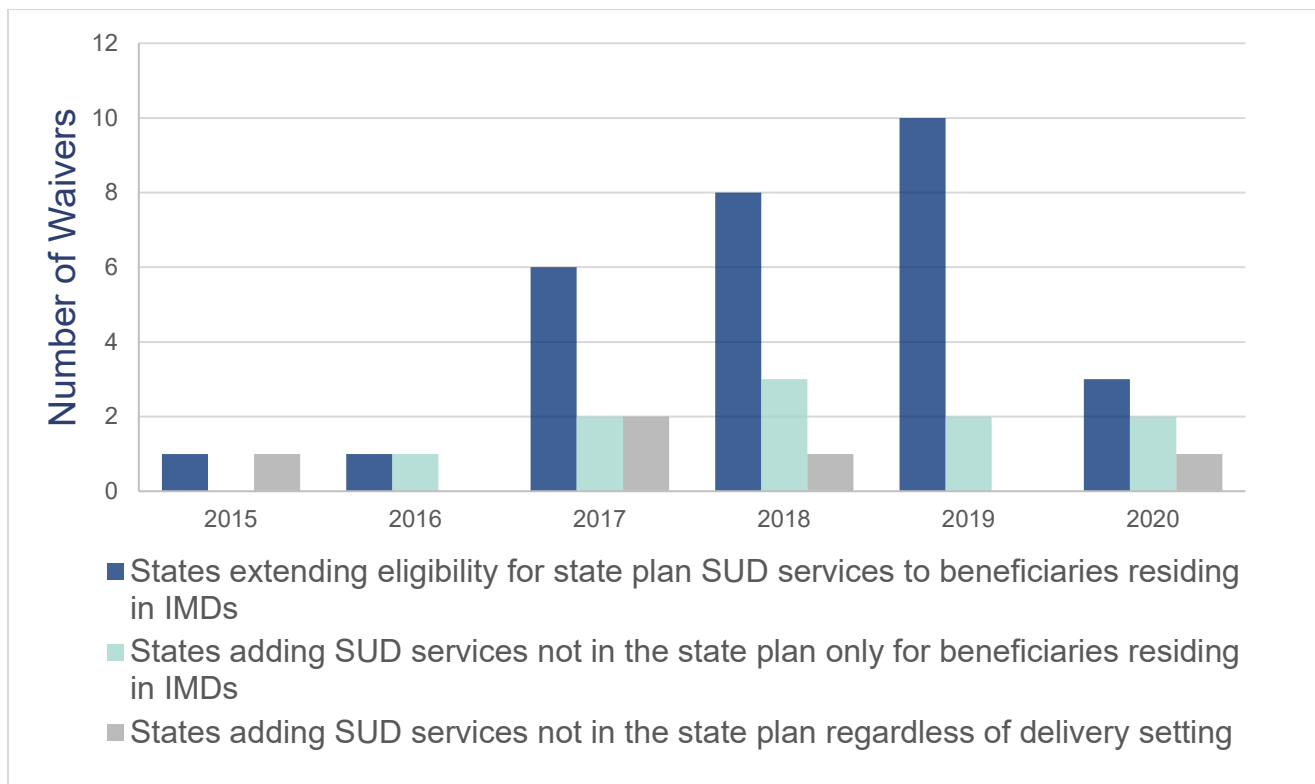
⁶² CMS, Special Terms and Conditions for West Virginia Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders Section 1115 Demonstration 7–10 (Oct. 6, 2017) <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wv/continuum-care/wv-creating-continuum-care-medicaid-enrollees-substance-creating-continuum-sud-stcs-20171010.pdf>.

⁶³ CMS, Special Terms and Conditions for the District of Columbia Behavioral Health Transformation Section 1115 Demonstration 10-11 (Jan. 6, 2021), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/dc/dc-behavioral-health-transformation-ca.pdf>.

Table 1: States with Approved 1115 SUD Waivers by Demonstration Purpose

States extending coverage of state plan SUD services to beneficiaries residing in IMDs	States adding SUD services not in the state plan only for beneficiaries residing in IMDs	States adding SUD services not in the state plan regardless of delivery setting
Alaska, California, Colorado, District of Columbia, Delaware, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, North Carolina, Nebraska, New Hampshire, New Jersey, New Mexico, Ohio, Oklahoma, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	Alaska, District of Columbia, Illinois, Indiana, Maryland, Massachusetts, Oklahoma, Rhode Island, Virginia, West Virginia	California (but not statewide), District of Columbia, Maryland, Massachusetts, West Virginia

Figure 1: Number of Approved 1115 SUD Waivers by Category and Year



Our review shows that most states with approved Section 1115 SUD waivers (twenty-seven) generally commit, as part of the waiver’s terms and conditions, to aim for an average length-of-stay at IMDs of thirty days. However, CMS has set more specific limits for three states (California, Maryland, and Oklahoma) and the District of Columbia. California limits coverage of services provided to a beneficiary at an IMD to two non-continuous days of ninety days each;⁶⁴ Maryland covers up to two non-consecutive stays of thirty days or less annually;⁶⁵ and

⁶⁴ CMS, *supra* note 61, at 130. While California’s waiver had this limit on coverable days at IMDs, the State has requested a one-year extension of the waiver in which it asks CMS to remove this limitation. See Cal. Dep’t of Health Care Servs., Request for 12-Month Extension of the Medi-Cal 2020 Section 1115 Waiver Demonstration 22-23 (Sept. 16, 2020), <https://www.dhcs.ca.gov/provgovpart/Documents/MC-2020-12-Month-Extension-Request-092820.pdf>.

⁶⁵ CMS, Expenditure Authority for Maryland HealthChoice Section 1115 Demonstration 3 (April 16, 2020), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/md/md-healthchoice-ca.pdf>. Maryland also covers medically managed intensive inpatient services for up to 15 days in a month for individuals twenty-one through sixty-four years of age who are residing in institutions for mental diseases (IMDs) and have a primary SUD diagnosis and a secondary mental health diagnosis. *Id.*

the terms and conditions for District of Columbia, Oklahoma and Idaho specify that stays of longer than sixty days will not be covered.⁶⁶ Notably, all of these states also included IMD waivers for SMI/SED. One state (Ohio) permits coverage of stays of more than thirty days by allowing managed care plans to use the ASAM placement criteria to authorize stays of thirty days or longer and to use prior authorization for three or more admissions to an IMD in a given year.⁶⁷ Finally, projects from three states (Indiana, Louisiana, and Massachusetts) do not specify day limits or average length-of-stay. These waivers generally limit coverage for services at IMDs to “short-term” stays. While not explicitly stated in the waivers, it is likely that CMS will interpret “short-term” to mean the required average length-of-stay of thirty days as stated in guidance provided by both the Obama and Trump administrations.⁶⁸

2. Medication-Assisted Treatment Services

Because of the importance of MAT as part of the standard of care for SUDs, we also reviewed the special terms and conditions of all approved Section 1115 SUD waivers for any provisions related to MAT. Waivers vary considerably regarding MAT provisions. Not surprisingly, almost all waiver projects (twenty-nine) specifically state that MAT or pharmacotherapy at opioid/narcotic treatment programs is covered for beneficiaries while in IMDs. Several states, however, go further. Sixteen waivers specify that all IMDs *must* offer MAT on-site or facilitate access to MAT off-site within twelve to twenty-four months of the waiver’s approval, a requirement included in the federal guidance issued by the Trump administration.⁶⁹ Still, several states also expand covered services related to MAT more broadly. California, for

⁶⁶ CMS, *supra* note 63, at 12; CMS, Special Terms and Conditions for Oklahoma Institutions for Mental Diseases Waiver for Serious Mental Illness/Substance Use Disorder Section 1115 Demonstration 19 (Dec. 22, 2020), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ok-imd-waiver-smi-sud-ca.pdf>.

⁶⁷ CMS, Implementation Plan for Ohio Section 1115 Substance Use Disorder Demonstration 15 (Sept. 24, 2019), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/oh-substance-use-disorder-treatment-demo-appvl-09242019.pdf>.

⁶⁸ CMS, Expenditure Authority for Indiana Healthy Indiana Plan Section 1115 Demonstration 1 (Feb. 1, 2018), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-cms-amend-appvl-02012018.pdf>; CMS, Expenditure Authority for Louisiana Healthy Louisiana Opioid Use Disorder/Substance Use Disorder Section 1115 Demonstration 1 (June 3, 2020), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/la/la-healthy-oud-sud-demo-ca.pdf>; CMS, Special Terms and Conditions for Massachusetts MassHealth Section 1115 Demonstration 54 (June 26, 2019), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-ca.pdf>.

⁶⁹ CMS, *supra* note 38, at 9.

example, now covers ordering, prescribing, administering, and monitoring of MAT through the State's waiver in addition to the cost of the prescription drugs.⁷⁰ The District of Columbia waiver exempts beneficiaries from the District's \$1 pharmacy co-pay when receiving MAT prescriptions.⁷¹ Finally, as required by the guidance issued by the Trump administration, most waivers include general statements requiring states to ensure sufficient MAT provider capacity.⁷² As discussed below, however, in most instances, information about implementation of this requirement is lacking.

3. Provisions for Youth

We reviewed all Section 1115 projects and requests for mentions of SUD services specifically for youth (see Table 2 for summary). The results described below are based solely on this review, as we did not look at other documents from the states to determine their compliance with EPSDT as it relates to SUD services. It is important to note that regardless of what is described in a Section 1115 waiver or state plan, states must still comply with EPSDT. For some states, CMS has made this explicit, such as California's waiver special terms and conditions which mentions that EPSDT is not waived. The findings in this section are focused on whether the waivers mention youth as an included population or contain specific provisions relating to treatment of youth with SUD, and do not reflect whether or not these states or programs are in fact complying with EPSDT.

Of the Section 1115 waivers reviewed, the special terms and conditions for sixteen states did not mention youth at all. In addition, the waiver for one state (Louisiana) only mentioned youth to state that both youth and adults are eligible for the same services, but made no distinction for the specifics of treating youth with SUD.⁷³ The waivers for two states (New Mexico and Oregon) contain provisions for services to specific groups of young people, while also mentioning that youth are part of the mandatory state plan population generally.⁷⁴ Finally,

⁷⁰ CMS, *supra* note 61, at 132.

⁷¹ CMS, *supra* note 63, at 31.

⁷² CMS, *supra* note 38, at 9.

⁷³ See, for example, CMS, Expenditure Authority for Louisiana Healthy Louisiana Opioid Use Disorder/Substance Use Disorder Section 1115 Demonstration, *supra* note 68, at 96.

⁷⁴ CMS, Special Terms and Conditions for New Mexico Centennial Care 2.0 Section 1115 Demonstration 38 (July 21, 2020), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-ca.pdf> (explicitly allowing for youth residential treatment for ages 18-21); Oregon Health Authority, Waiver Application for Oregon Health Plan Substance Use Disorder Section 1115 Demonstration 21-25 (May 29, 2020), <https://www.medicaid.gov/medicaid/section-1115->

the waiver in one state (Arizona) specifically excludes youth under age twenty-one (and older adults over age sixty-four) from their proposed demonstration population.⁷⁵ The remaining waivers (eighteen states, including New Mexico and Oregon) contain either specific services for the treatment of youth with SUD, have programs to serve specific populations of young people, such as youth involved in the foster care system, or do both of these options. Special terms and conditions for waivers in thirteen states discuss guidelines or requirements for treating SUD in youth that differ from the provisions for services of adults. For example, Illinois's program includes intensive in-home support for youth in need of stabilization.⁷⁶ In addition, California's and Virginia's waivers mention that services for youth should be based on the ASAM criteria for young people (despite the fact that ASAM criteria is not the same as medically necessary services under EPSDT).⁷⁷

Further, waiver projects in nine states single out specific youth populations for SUD services under their demonstration, such as youth in foster care (Maine, Massachusetts, New Mexico, North Carolina, Oregon, and Rhode Island), youth leaving incarceration (Kentucky), and youth experiencing Serious Emotional Disturbances (SED) and Serious Mental Illnesses (SMI) (District of Columbia, Kansas, Rhode Island, and Vermont). Some of these states created programs and policies to coordinate care across systems serving youth, such as Rhode Island's program working with the Department of Children, Youth, and Families to provide preventative services to youth at risk of entering out-of-home care or hospitalization.⁷⁸ Maine's waiver request attempted to create a similar pilot program, but that portion of the demonstration

[demonstrations/downloads/or-health-plan-sud-demo-pa.pdf](#) (indicating various youth population groups that are eligible to receive services under the demonstration).

⁷⁵ Arizona Health Care Cost Containment System, Arizona Section 1115 Waiver Amendment Request: Institutions for Mental Disease (IMD) 5 (May 3, 2017),

<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-pa5.pdf>.

⁷⁶ CMS, *supra* note 54, at 19.

⁷⁷ CMS, *supra* note 61, at 121; CMS, Special Terms and Conditions for Virginia Governor's Access Plan (GAP) and Addiction and Recovery Treatment Services (ARTS) Delivery System Transformation 54 (Dec. 15, 2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/va/Governors-Access-Plan-GAP/va-gov-access-plan-gap-appvl-amdmnt-12152016.pdf>

<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/va/Governors-Access-Plan-GAP/va-gov-access-plan-gap-appvl-amdmnt-12152016.pdf>

⁷⁸ CMS, *supra* note 59, at 73.

request was not granted.⁷⁹ Waivers from other states (New Mexico and Oregon) included youth in general, including foster youth.⁸⁰

Table 2: Mention of SUD Services for Youth in State 1115 Waivers

Youth Not Mentioned or Excluded	Youth Included in General Population	Specific Provisions for Youth Services in IMDs⁸¹	Specific Provisions for Youth Services Not in IMDs	Services for Specific Youth Populations (Not in IMDs)
Arizona, Idaho, Indiana, Maine, Maryland, Michigan, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, Oklahoma, Pennsylvania, Utah, Wisconsin, West Virginia	Louisiana, New Mexico*, Oregon*	New Mexico*~, Oregon*, Tennessee	Alaska~, California, Colorado, District of Columbia~, Illinois, Kansas~, Virginia, Washington	Alaska~, District of Columbia~, Delaware, Kansas~, Kentucky, Massachusetts, North Carolina, New Mexico~, Rhode Island, Vermont

**New Mexico and Oregon both included youth in the general population for the demonstration and included provisions for specific populations of youth (youth in foster care).*

~ These states include both specific treatment/service guidelines for youth with SUD generally and also provisions for specific youth populations.

⁷⁹ Maine Dep’t of Health and Human Servs., 1115 Waiver Application: Substance Use Disorder Care Initiative 11-13 (Nov. 26, 2019), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/me/me-sud-care-initiative-pa.pdf> (requesting approval for funding related to parenting support programs).

⁸⁰ CMS, *supra* note 74, at 188; Oregon Health Authority, *supra* note 74, at 30.

⁸¹ It is important to note that while these states received waivers which included authorization for services for young people in IMDs, a waiver was not necessary. States may provide such services through existing state plan authority through the “psych under twenty-one” benefit. See Hernández-Delgado & Lewis, *supra* note 29.

4. Provider Availability and Payment/Delivery System Reforms

A stated goal of some Section 1115 SUD projects is the expansion of availability of SUD providers and improvements in coordination and integration of SUD services between the different levels of care and with other health services. Importantly, states do not need a waiver of Medicaid Act requirements to achieve many of these goals.⁸² Nonetheless, because of the central component that provider availability and delivery system reforms play in some of these projects, we included an analysis of these policies in our review.

Federal guidance from the Trump administration included requirements regarding provider availability and coordination of care. Within twelve months of approval, states must complete an assessment of the availability of providers who are enrolled in Medicaid and accepting new patients at the following levels of care: MAT, outpatient, intensive outpatient, residential, inpatient, and medically supervised withdrawal management.⁸³ Furthermore, to improve and maintain quality, states must ensure within twelve to twenty-four months following approval, that residential providers meet the ASAM criteria or other nationally recognized, evidence-based, SUD-specific program standard.⁸⁴ All waivers approved by the Trump administration include general statements requiring compliance with this provision and states generally show compliance with these requirements through the SUD implementation plan submitted subsequently.

While a small minority, some states have utilized their Section 1115 SUD waivers to go further to increase provider availability and/or ensure quality of care through payment and delivery system reforms. Reforms in this area include actions like incorporating ASAM standards of care into provider and managed care contracts in Virginia and establishing rates for SUD providers separate from the state plan rates in Vermont, which allows the State to improve rates to attract more SUD providers and maintain tight certification requirements for quality

⁸² Some of the options that states have to implement payment and delivery system reforms for SUD services outside of Section 1115 include: use of health homes or certified community behavioral health clinics (CCBHCs) as an option to deliver SUD services in coordination with other services (*see* 42 U.S.C. § 1396w-4 for the state option to establish health homes for Medicaid beneficiaries with chronic conditions, including SUDs; *see* 42 U.S.C. § 1396a note for the demonstration program that authorizes the use of CCBHCs); coverage and implementation of targeted case management services and recovery support services (*see* 42 U.S.C. § 1396n(g)); and introducing certain requirements for care coordination for individuals with SUD into managed care contracts.

⁸³ CMS, *supra* note 38, at 8.

⁸⁴ *Id.* at 9.I

purposes.⁸⁵ In terms of delivery system reform, various states have established comprehensive programs to make access to the SUD system of care more available and seamless. For instance, Alaska’s waiver seeks to create an integrated behavioral health system for all Medicaid and CHIP beneficiaries with serious mental illness, severe emotional disturbance, mental health disorders, and SUD.⁸⁶ The aim of this program is “to establish networks of support for individuals and family members.”⁸⁷

5. Access to Continuum of Care and Community-Based Services

Most Section 1115 waivers’ special terms and conditions purport to ensure that Medicaid beneficiaries with SUD have access to the whole continuum of care for SUD treatment, using the ASAM continuum of care to inform expansion of services. Waiving the IMD exclusion allows states to claim FFP for services provided in placements that are recommended by ASAM level of care 3 and its corresponding intensity levels (3.1, 3.3, 3.5, and 3.7) and, in some cases, level of care 4, in facilities that are classified as IMDs (states are free to cover services in both level 3 and 4 under the Medicaid Act as long as they are provided in smaller facilities). As such, we reviewed approved Section 1115 SUD projects to evaluate the extent to which states are incorporating the whole ASAM continuum of care into their demonstrations. In addition, we reviewed the extent to which approved waivers cover the continuum of care for withdrawal management, based on the ASAM Withdrawal Management Levels of Care. See Appendices 2 and 3 for a summary of the ASAM placement criteria and ASAM withdrawal management levels of care.

Of the thirty-one approved waivers, twenty-one states explicitly reference the ASAM continuum of care and delineate the levels covered through the waiver and/or the state plan. Most of these states establish that the state plan already covered (or will cover through a subsequent SPA) pre-3.0 ASAM levels of care and they use the waiver specifically to add coverage of ASAM levels 3 and 4. For example, New Mexico’s waiver establishes that the State will be submitting a SPA to cover ASAM levels of care 0.5, 1.0, 2.1, 2.5, 3, 3.7, and 4, but the State used waiver authority to use FFP to pay for services provided in placements that correspond with levels 3, 3.7, and 4.⁸⁸ Similarly, Nebraska’s waiver states that the State covers, through the state plan or Section 1915(b) authority, ASAM levels of care 1.0, 2.1, 2.5,

⁸⁵ CMS, *supra* note 77, at 47; CMS, Waiver Authority for Vermont Global Commitment to Health Section 1115 Demonstration 2 (Oct. 24, 2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/Global-Commitment-to-Health/vt-global-commitment-to-health-ext-appvl-10242016.pdf>.

⁸⁶ CMS, *supra* note 56, at 14.

⁸⁷ *Id.*

⁸⁸ CMS, *supra* note 74, at 142–143.

3.1, 3.3, and 3.5.⁸⁹ But the waiver gives the State authority to cover levels 3.1, 3.3, and 3.5 when requiring stays of more than fifteen days in IMDs.⁹⁰ In general, states that rely on waiver authority exclusively for ASAM placement levels 3 and 4 fall into the categories of states expanding state plan services to beneficiaries in IMDs or adding new services but limiting eligibility to beneficiaries in IMDs (see Table 1 above). This is because these states typically emphasize modifications to coverage of different placement levels (that is, settings) and not necessarily changes to the types of services covered.

CMS has utilized Section 1115 to allow states to expand services to cover ASAM's whole continuum of care. California, for example, was granted a waiver to cover opioid treatment programs, ASAM levels of care 1, 2.1, 2.5, 3.1, 3.3, and 3.5 (in addition to others covered in the state plan) in counties participating in the demonstration.⁹¹ As a practical matter, ASAM's continuum includes services provided in both residential and inpatient settings, and most of those settings have more than sixteen beds. Thus, FFP is often prohibited for services in these settings. However, no waiver is needed to provide SUD services in these settings as long as the setting has sixteen or fewer beds. Furthermore, pursuant to the SUPPORT Act, a state plan option is available to states to cover SUD services in IMDs. However, only one state has used this authority, and even that state wound down its state plan option once it had an approved Section 1115 project.⁹² The rest of the states have pursued Section 1115 waivers to cover the services in post 3.0 ASAM levels of care.

Finally, we reviewed coverage of ASAM withdrawal management (ASAM-WM) levels of care. Fourteen waivers specifically mention ASAM-WM levels of care, most of which are closely aligned with the ASAM placement levels of care. In ten of these states, WM levels are addressed only to the extent that Section 1115 authority was utilized to cover these services when provided in residential settings classified as IMDs. Other waivers, particularly some of

⁸⁹ Section 1915(b) of the Social Security Act gives states the flexibility to modify their delivery systems by allowing CMS to waive the statutory requirements of comparability, statewide, and freedom of choice. States typically use Section 1915(b) waivers to enact managed care reforms.

⁹⁰ CMS, Implementation Plan Protocol for Nebraska Substance Use Disorder (SUD) Program Section 1115 Demonstration 5-6 (Nov. 16, 2020), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ne/ne-sud-demo-ca.pdf>.

⁹¹ CMS, *supra* note 61, at 124–125.

⁹² See CMS, Idaho State Plan Amendment #19-0023 (April 7, 2020), <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/ID/ID-19-0023.pdf> (for approval of the SPA); see CMS, Idaho State Plan Amendment # 20-0013 (June 23, 2020), <https://www.medicaid.gov/medicaid/spa/downloads/ID-20-0013.pdf> (for removal of the SPA).

the earlier ones, utilized Section 1115 waiver authority to make various WM levels of care available for the first time regardless of delivery setting. Those states are: Alaska (covering WM levels 1, 2, 3.2, 3.7, and 4);⁹³ California (requiring counties to cover at least one WM level);⁹⁴ and New Mexico (covering WM levels of care 2 and 3.7).⁹⁵

Because there is an increasing trend of states relying on Section 1115 waivers simply to obtain FFP for services provided in IMDs, we reviewed provisions in the special terms and conditions aimed at maintaining a proper balance between residential and inpatient treatment and outpatient and community-based services. As mandated by CMS, most Section 1115 SUD projects include a statement generally pledging to establish and implement policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays. Also, most waiver terms and conditions include language incorporating the requirement to establish a utilization management approach to monitor patient placement, including an independent process for reviewing placement in residential settings within twelve to twenty-four months of waiver approval. Our review shows that most waivers' terms and conditions do not go beyond these general statements.

Several states have included more specific policies to ensure proper coordination and transitions between levels of care. In fact, some states added community-based SUD services through their Section 1115 waivers. For example, in West Virginia's waiver's special terms and conditions, the state committed to expanding access to care coordination services to facilitate linkages with community resources.⁹⁶ Similarly, Rhode Island committed to establishing triage centers to provide screening and evaluations, crisis intervention services (including mobile outreach services), case management, peer support, treatment coordination, discharge planning, and warm hand-offs to community providers and medications.⁹⁷

Other states simply proposed to strengthen coordination of care requirements beyond the general statement found in most waivers. Ohio's waiver's special terms and conditions, for example, requires all residential facilities, including IMDs, to have in place a discharge plan for each beneficiary receiving services in the facility, which must include proper care coordination

⁹³ CMS, Implementation Plan for Alaska Substance Use Disorder Treatment and Alaska Behavioral Health Program Section 1115 Demonstration 18-21 (Sept. 3, 2019), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/ak-behavioral-health-demo-ca.pdf>.

⁹⁴ CMS, *supra* note 61, at 126.

⁹⁵ CMS, *supra* note 74, at 142.

⁹⁶ CMS, *supra* note 62, at 10.

⁹⁷ CMS, *supra* note 59, at 75.

with lower levels of care outside of the facility.⁹⁸ Under Virginia’s waiver’s special terms and conditions, residential providers are expected to link individuals with community resources to facilitate referrals and respond to social service needs, not just clinical ones.⁹⁹ Virginia providers are also expected to track and support individuals when they obtain medical, behavioral health, or social services outside their settings.¹⁰⁰

E. Policy Considerations

1. Overreliance on Section 1115 Projects to Expand SUD Services

States can make many of the improvements they have sought to achieve via Section 1115 waivers through a Medicaid SPA. This includes expansion of services, such as additional MAT services (prescribing, monitoring, etc.), case management, and peer support. This would also include policy reforms that seek to implement coverage for the full continuum of care, and improve integration and coordination of care for SUD services. The Medicaid Act does not limit states’ ability to enact such reforms, as long as they continue to comply with general requirements, such as comparability, statewideness, and freedom of choice. Furthermore, in granting states’ Section 1115 applications, the Secretary has subverted the purpose of Section 1115 and exceeded their authority.

2. Policy Patterns and Gaps in Section 1115 Projects

States’ Focus on Residential Treatment at IMDs at the Expense of Other Services

As explained previously, states do not need waivers to provide additional SUD services along the full continuum of care under Medicaid. Even residential treatment services can be covered in a myriad of ways: via the 1915(I) state plan option; or in facilities with sixteen beds or less; or via “in lieu of authority” through managed care organizations for up to fifteen days per calendar month.¹⁰¹ However, our analysis showed that one of the main reasons states use Section 1115 authority is to obtain FFP for services provided in IMDs, and our analysis uncovered significant differences in the way in which states did this under the Obama

⁹⁸ CMS, *supra* note 67, at 38.

⁹⁹ CMS, Special Terms and Conditions for Virginia Governor’s Access Plan (GAP) and Addiction and Recovery Treatment Services (ARTS) Delivery System Transformation, *supra* note 77, at 45–46.

¹⁰⁰ *Id.*

¹⁰¹ CMS, Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) Frequently Asked Questions (FAQs) – Section 438.6(e), August 2018, <https://www.medicaid.gov/federal-policy-guidance/downloads/faq08172017.pdf>.

administration (from 2015 to 2017) and the Trump administration (from 2018 to present). As Table 1 and Figure 1 show, before 2018, several states received approval for projects that not only sought to use FFP for residential SUD treatment at IMDs, but also sought to expand the availability of SUD services overall, regardless of the delivery setting. Projects approved under the Trump administration, in contrast, focused almost entirely on seeking to waive the IMD exclusion.

While federal guidance on SUD services issued by both the Obama and Trump Administrations share many similarities, they differ in some significant ways with respect to the IMD exclusion waiver. The 2015 federal guidance clearly lays out how states would be expected to implement policies that would “transform” the SUD system of care and delineates several steps to achieve this goal. In addition, under the 2015 guidance states were expected to guarantee the full continuum of evidenced-based care that includes benefits like SBIRT, withdrawal management, MAT, care coordination, and long-term recovery supports and services. Short-term residential services were made available in order to “supplement and coordinate with, but not supplant, community-based services and supports.”¹⁰² Early waivers, such as California’s, Massachusetts’s, and Maryland’s, reflected these requirements, and included in their applications the stated goal of expanding, improving, and maintaining the *whole* SUD continuum of care (including early intervention services, outpatient and at-home opioid treatment services, intensive outpatient services, partial hospitalization, and, when medically necessary and with consent of the patient, residential and inpatient treatment), even though some of these waivers also implemented restrictions to accessing care, such as waivers of statewideness and freedom of choice.

By contrast, the 2017 Trump Administration guidance is clear from the beginning that it represents “a *more flexible, streamlined approach* to accelerate states’ ability to respond to the national opioid crisis...” (emphasis added). The 2017 federal guidance includes only general statements asking states to indicate how residential services would supplement and coordinate with other levels of care, and removed language that appeared in the 2015 guidance asking states not to supplant community-based services funding for funding for residential services. The 2017 guidance also fails to include any specific requirement to ensure the whole continuum of care is available.

Further, the Trump Administration has failed to require proper care coordination across the entire treatment system, and instead has granted waivers where the only requirements regarding care coordination are focused on linkages to community-based services and supports for enrollees leaving residential and inpatient facilities. While this is certainly an

¹⁰² CMS, *supra* note 37, at 7.

important policy, CMS has not required states to develop and maintain the whole continuum of care to allow patients to receive care in the lowest placement level necessary. This is problematic because studies have shown that residential SUD programs are prone to admitting patients with SUD without assessing whether residential treatment is appropriate and whether lower levels of care would yield the same or better results.¹⁰³ In contrast, some of the early SUD waivers sought to transform the way Medicaid beneficiaries with SUD receive care by ensuring better coordination and transitions of care between placement levels. These early waiver states made access to the different levels of care more seamless through a centralized and coordinated system. While many gaps remain in practice and more improvements are needed, the achievements of these early projects were clearer and contrast with the more limited focus of newer waivers. Yet even these projects incorporated illegal and unnecessary provisions by using Section 1115 to waive statewideness, allowing FFP for IMDs, and maintaining significant gaps in terms of availability of SUD providers in the communities. While some of the reforms achieved through these waivers have been positive, those states could have and should have achieved those reforms via a state plan authority.

Finally, our analysis showed that over time, states have been less likely to include limitations on the number of days they could obtain FFP for a beneficiary receiving treatment in an IMDs. While both the 2015 and 2017 federal guidance simply ask that states achieve a statewide average length-of-stay of thirty days or less, and despite neither letter requiring specific limits on days covered, we found that several early waivers included explicit limits, as explained in section D.1 above. These limits helped ensure that beneficiaries were placed in the lowest level of care necessary, and created incentives for providers to coordinate care with and transitions to lower levels of care.

Conflation of Placement and Services

Many states have conflated the ASAM placement criteria with the specific SUD services that an individual may need. While the ASAM criteria may overlap with medical necessity, it is essential for states to understand that recommended services could be the same regardless of the ASAM placement level. For example, an individual could receive MAT, counseling, and peer support in a residential facility or outside of it. “Residential treatment” is a location, or a delivery model at best, but it is not a defined package of services. Lack of information and misunderstanding about this concept makes it harder for states to use the correct legal tools to achieve availability of the whole SUD continuum of care. Although states and CMS have

¹⁰³ See, for example, Tamara Beetham et al., *Admission Practice and Cost of Care for Opioid Use Disorder at Residential Treatment Programs in the U.S.*, 40 HEALTH AFF. 317 (2021), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00378>.

highlighted the use of Section 1115 as a way to expand availability of services, the main change many state projects seek to achieve is obtaining FFP for IMDs, irrespective of the actual services provided in these settings. States' laser-focus on obtaining FFP for IMDs belies the need to ensure that certain specific benefits are covered and available *regardless* of the setting in which they are provided.

Most Medicaid programs already cover some SUD services through their state plan. For example, medications for substance or opioid use disorders used for MAT may be part of the prescription drugs benefits category, counseling and crisis intervention is often covered as part of the rehabilitative benefits category, and case management is a separate reimbursement category. Our review shows that most states are relying on Section 1115 SUD waivers to seek Medicaid reimbursement for SUD services provided to beneficiaries in IMDs without consideration as to whether the same services are available outside of these facilities and whether enough providers are available. For example, several projects made MAT services available for IMD patients. While MAT is the gold standard of care in any setting, states should also focus on eliminating prior authorization, step therapy requirements, quantity limits, and other barriers to accessing buprenorphine and methadone for Medicaid beneficiaries, as well as encouraging and facilitating access to opioid treatment programs through mobile units and more flexible coverage requirements.

While this review does not examine state Medicaid plans on this level, recent studies about the availability of MAT in Medicaid indicate that gaps remain regardless of placement level.¹⁰⁴ In addition, a recent study that looked at the impact of Section 1115 SUD projects in particular, found that Medicaid billing in residential facilities increased significantly, pointing towards greater utilization of residential treatment than other settings, whereas utilization of essential

¹⁰⁴ For example, fifty-state surveys of state Medicaid coverage of all three FDA-approved medications for MAT have demonstrated that many states either do not cover or impose prior authorization, quantity limits, and other barriers on access to buprenorphine and methadone for MAT, and on the overdose-reversal medication naloxone. See SAMHSA, *Medicaid Coverage of Medication-Assisted Treatment for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose* (2018), <https://store.samhsa.gov/product/Medicaid-Coverage-of-Medication-Assisted-Treatment-for-Alcohol-and-Opioid-Use-Disorders-and-of-Medication-for-the-Reversal-of-Opioid-Overdose/SMA18-5093>. NHeLP is currently performing an analysis of gaps regarding access to MAT in Medicaid programs regardless of delivery setting.

services, such as MAT for OUD, did not increase in residential facilities and increased only modestly in outpatient facilities.¹⁰⁵

Strengthening outpatient and community-based service availability is important because the vast majority of individuals with SUD do not require residential services.¹⁰⁶ In fact, overemphasizing residential care over other community-based services may have the effect of reallocating resources towards institutional settings and may lead to a decrease in the availability of outpatient services, leaving patients with fewer options other than to receive the same services in residential or inpatient settings despite the fact that such level of care may not be medically necessary. If beneficiaries are placed in residential facilities not because they need such level of care, but because they cannot obtain the same-life-saving services in the community, this violates basic principles of consent and autonomy. As countless studies have shown, accessing treatment through explicit or implicit coercion is ineffective and may be counterproductive to the course of treatment and unfortunately continues to happen in a widespread manner in the behavioral health field.¹⁰⁷

Confusion about the interplay between placement criteria and individual service needs may also make it harder for beneficiaries to access services. All states have set medical necessity criteria to access services through Medicaid and such criteria for adults typically authorizes coverage for services that are reasonably needed to prevent and treat conditions that affect or endanger the person's life. Our review, however, shows that some states have adopted the ASAM *placement* criteria as their medical necessity criteria. That is, an individual must be eligible for a certain ASAM level to access some services. Instead, states should engage in a two-step process. The state must separately determine whether an enrollee is eligible for a specific service by applying the state's medical necessity criteria. ASAM placement criteria should be used solely for the purpose of determining the setting in which the person should

¹⁰⁵ Johanna Catherine Maclean et al., *Institutions for mental Diseases Medicaid Waivers: Impact on Payments for Substance Use Treatment Facilities*, 40 HEALTH AFF. 326 (2021), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00404>.

¹⁰⁶ See, i.e., Jane Witbodt et al., *Day Hospital and Residential Addiction Treatment: Randomized and Nonrandomized Managed Care Clients*, 75 J. CONSULT. CLIN. PSYCH. 947 (2007), <https://pubmed.ncbi.nlm.nih.gov/18085911/>; Dominique de Andrade et al., *The Effectiveness of Residential Treatment Services for Individuals with Substance Use Disorders: A Systemic Review*, 201 DRUG & ALCOHOL DEPENDENCE 227 (2019), <https://doi.org/10.1016/j.drugalcdep.2019.03.031>.

¹⁰⁷ For a literature review of the evidence surrounding coerced or compulsory SUD treatment, see Dan Werb et al., *The Effectiveness of Compulsory Drug Treatment: A Systematic Review*, 28 INT. J. DRUG POLICY 1–9 (2016) (finding that the "evidence does not, on the whole, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms).

receive services, not whether the individual is entitled to the services that will be delivered in that location. Any other approach risks creating additional barriers to enrollee access to services. Utilizing ASAM as a surrogate for medical necessity also violates the EPSDT mandate that requires states to provide services needed to correct or ameliorate a condition (to Medicaid beneficiaries under age twenty-one).

Availability of Medication-Assisted Treatment for Beneficiaries in Residential Facilities

We sought to determine the extent to which states are relying on Section 1115 waivers to expand access to MAT (particularly to buprenorphine and methadone) for individuals residing in IMDs or other residential settings. Recent studies have indicated the vast majority of residential SUD treatment programs are not offering MAT, making their treatment ineffective, and in some cases harmful, for most of their patients.¹⁰⁸ We found that some—but not all—recent Section 1115 projects have required IMDs to demonstrate, as a condition of participation, that they can offer MAT on-site or are able to refer patients to MAT off-site. As noted above, sixteen waivers specify that all IMDs *must* offer MAT on-site or facilitate access to MAT off-site within twelve to twenty-four months of the waiver’s approval, which means that almost half of the states that obtain FFP for IMDs *do not* require provision of MAT. Even for those waivers that require provision of MAT in IMDs, more research is needed to determine whether IMDs are complying with this new requirement, and better regulations are needed to ensure effective treatment is provided and evidenced-based practices are followed.

Provisions for Youth

The majority of states did not mention youth at all. Of those who did mention youth, many only included specific populations, such as youth formerly in foster care. While youth in these populations are more likely to experience SUD and have serious health needs, SUD services should be available for all Medicaid eligible youth pursuant to EPSDT and therefore a waiver is not appropriate to address services to those beneficiaries under age twenty-one. In addition, states can build systems of care for SUD via their state plans, without a Section 1115 waiver. Further, the inclusion of select beneficiaries under age twenty-one in those state waivers

¹⁰⁸ See, i.e., Tamara Beetham et al., *Therapies Offered at Residential Addiction Treatment Programs in the United States*, 324 JAMA, 804 (2020), <https://jamanetwork.com/journals/jama/article-abstract/2769709> (finding that only about twenty-nine percent of surveyed residential programs were offering buprenorphine or methadone maintenance treatment, and twenty-one percent actively discouraged its use).

raises questions about how states are complying with their EPSDT obligations to children and youth with SUD.

Researchers and experts on effective SUD services for youth, including ASAM, agree that youth with SUD have specific service needs that differ from adults. For example, in order to effectively reach and treat youth, community-based connections, specific outreach and communication methods that work well for youth, and services that treat the whole family are essential.¹⁰⁹ There is a need for more federal guidance to states on the treatment obligations for youth with SUD, in particular.

Some states have established criteria for accessing SUD services that are more stringent than the EPSDT medical necessity criteria. For example, California's current waiver states that to access waiver services, beneficiaries under twenty-one must meet the ASAM criteria definition for medical necessity for services, while at the same time explicitly stating in the special terms and conditions the State must continue to meet its EPSDT obligations. As previously explained, this confuses medical necessity with placement level criteria. It also contravenes the State's EPSDT obligations. Additional research is needed to address the question of states' current compliance with EPSDT.

F. Recommendations

In light of our findings and analysis, we offer the following recommendations for CMS to address coverage gaps regarding SUD services in Medicaid programs:

Recommendation #1: CMS should rescind its 2015 and 2017 federal guidance and produce new guidance encouraging states to expand access to the whole continuum of care and improve provider availability through SPAs or other authorities that do not misuse Section 1115 to obviate the requirements of the Medicaid Act. The guidance should advise states seeking to obtain FFP for residential SUD treatment that the states must comply with the requirements of the IMD exclusion when doing so. Such guidance could explain the option to utilize the SUPPORT Act's IMD optional benefit as an alternative.

Recommendation #2: CMS should reject any Section 1115 SUD waiver proposal that does not strictly adhere to the Section 1115 requirements. This includes any SUD waiver that requests waiver of provisions outside of 42 U.S.C. § 1396a (including the IMD exclusion), that requests

¹⁰⁹ NASADAD, *State Adolescent Substance Use Disorder Treatment and Recovery Practice Guide* (Sept. 24, 2014), <http://nasadad.org/wp-content/uploads/2014/09/State-Adolescent-Substance-Use-Disorder-Treatment-and-Recovery-Practice-Guide-9-24-14.pdf>.

a waiver of a provision that is unnecessary to carry out the demonstration, or that fails to specifically describe the experiment or demonstration, as well as what specific methods will be used to evaluate the hypothesis and whether the experiment or demonstration met the proposed outcomes that are expected or anticipated.

Recommendation #3: While states should continue adopting the ASAM standard of care and require SUD providers to use it, federal guidance should be provided to states clarifying that ASAM placement criteria should only be used to determine level of care, *after* medical necessity for a specific SUD service has been determined.

Recommendation #4: States should be required to demonstrate that they have removed all prior authorization, step therapy, quantity limits, and similar barriers to accessing MAT with buprenorphine and methadone prior to obtaining approval of any federal flexibilities through the appropriate use of Section 1115 waivers. States should also be required to demonstrate that they are making efforts to expand availability of MAT in different communities and that limits on accessing MAT treatment are not more stringent than federal requirements.

Recommendation #5: CMS should provide further guidance to states regarding the standard of care for individuals under twenty-one with or at risk of developing a SUD. The guidance should clarify and underscore states' responsibilities under the EPSDT mandate and the obligation to provide all behavioral health services, including home and community-based services, to children and youth with SUDs. In addition, CMS should provide guidance to states on opportunities to implement a SUD system of care for children and youth that takes into consideration the particular needs of this population.

G. Conclusion

While states have sought approval of Section 1115 SUD waivers for narrow and broad purposes, a close evaluation of approved state waivers and some of the proposed pending waivers shows that states have not addressed the needs of beneficiaries to access to SUD treatment in a manner that meets the growing needs of these individuals nor have they met the specific requirements of Section 1115 demonstrations. Through many of these waivers, states have weakened efforts to reinforce community-based SUD services while increasingly only seeking Section 1115 waiver authority to obtain Medicaid funding for treatment in residential facilities that are IMDs.

Appendices

Appendix 1: Summary of Findings

State	Effective Date	Expanding existing services to beneficiaries in IMDs	New services only for those in IMDs	New Services for all beneficiaries	Day limits at IMDs	ASAM Levels of Care ¹¹⁰	ASAM WM Levels of Care ¹¹¹	MAT Provisions ¹¹²	Community-Based Provisions ¹¹³	Services specific for youth ¹¹⁴
AK	Jan. 2019	X	X			X	X	X	X	X
AZ	Pending	X								
CA	Aug. 2015	X		X	X	X	X	X	X	X
CO	Jan. 2021					X		X	X	X
DC	Jan. 2020	X	X	X		X	X	X	X	X
DE	Aug. 2019	X				X		X	X	X
ID	April 2020	X				X	X	X	X	

¹¹⁰ Most states cover only levels 3 and up through waiver authority, but all states that cover at least some ASAM levels of care were included in the table.

¹¹¹ States may cover withdrawal management without referencing the ASAM WM criteria. Only states using the ASAM WM criteria were included in the table.

¹¹² Includes both general requirements for IMDs to provide MAT or link to MAT providers and, as well as ensuring sufficient providers of MAT, and other expansions of MAT services generally.

¹¹³ Includes waiver expansions of lower levels of care; requirements that residential facilities link individuals with community-based services; requirements for proper transitions, etc.

¹¹⁴ Includes waivers with specific provisions for youth and waivers with services for specific youth populations.

State	Effective Date	Expanding existing services to beneficiaries in IMDs	New services only for those in IMDs	New Services for all beneficiaries	Day limits at IMDs	ASAM Levels of Care	ASAM WM Levels of Care	MAT Provisions	Community -Based Provisions	Services specific for youth
IL	July 2018	X	X			X		X	X	X
IN	Feb. 2018	X	X			X		X		
KS	Jan. 2019	X				X		X	X	X
KY	Jan. 2018	X		X ¹¹⁵				X		X
LA	Feb. 2018	X				X	X	X	X	
MA	July 2017		X	X		X				X
ME	Jan. 2021	X						X	X	
MD	Jan. 2017	X	X	X	X	X	X			
MI	April 2019	X						X	X	
MN	July 2019	X						X	X	
MO	Pending			X ¹¹⁶						
NC	Nov. 2019	X						X	X	X
NE	July 2019	X				X	X	X	X	
NH	July 2018	X					X ¹¹⁷	X	X	

¹¹⁵ A pending amendment to Kentucky’s existing Section 1115 Section SUD waiver would expand services to cover incarcerated individuals. Otherwise, the waiver simply expanded state plan services to individuals in IMDs.

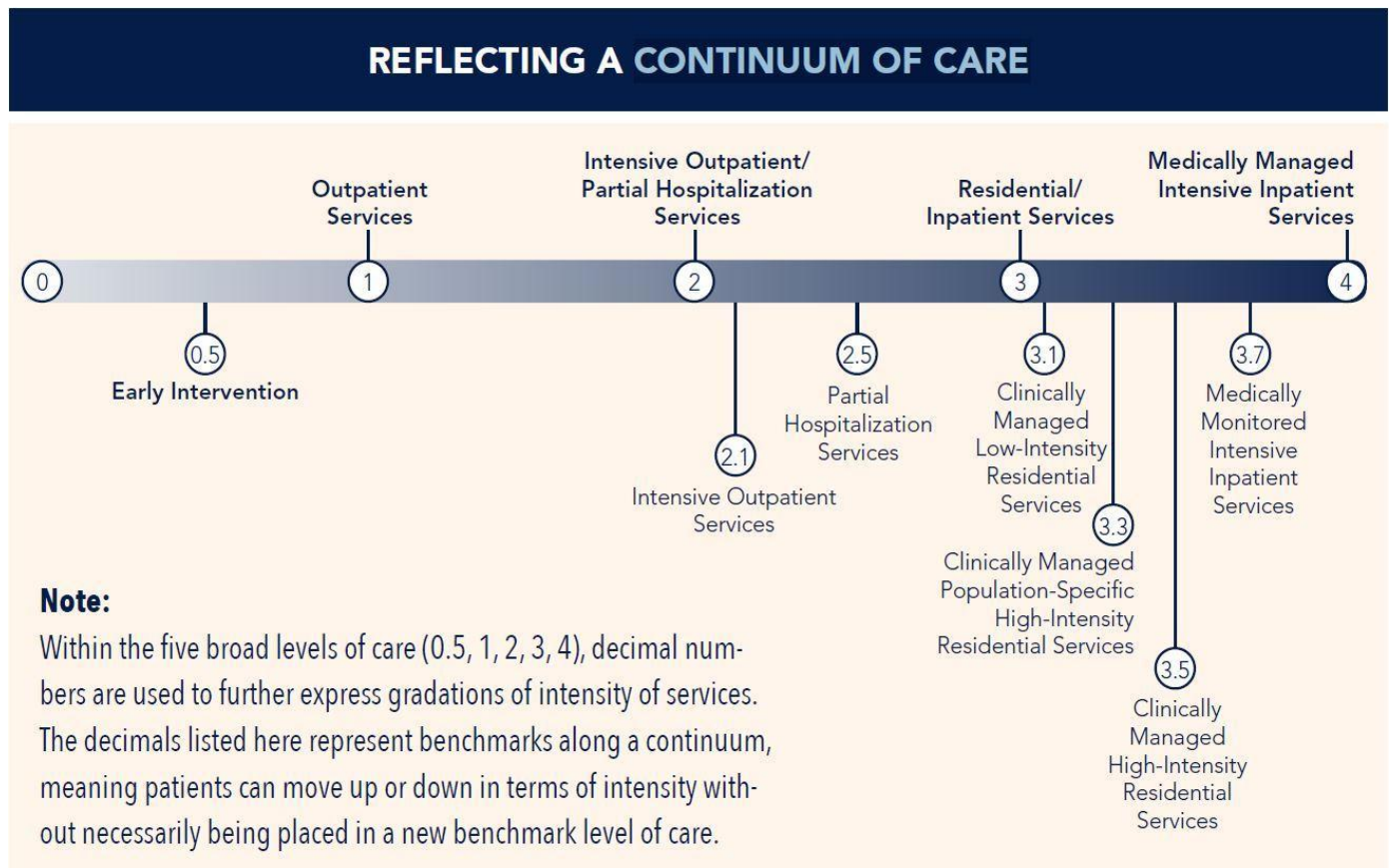
¹¹⁶ Missouri’s pending waiver would implement a Targeted Benefits for Pregnant Women Demonstration to provide ongoing SUD and mental health treatment for twelve months after the termination of pregnancy benefits following the birth of a child. It would be the first SUD waiver approved without an IMD exclusion waiver and similar continuum of care reforms.

¹¹⁷ All levels covered through state plan.

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State	Effective Date	Expanding existing services to beneficiaries in IMDs	New services only for those in IMDs	New Services for all beneficiaries	Day limits at IMDs	ASAM Levels of Care	ASAM WM Levels of Care	MAT Provisions	Community -Based Provisions	Services specific for youth
NJ	Aug. 2017	X			X		X	X	X	
NM	Jan. 2019	X				X	X	X		X
OH	Oct. 2019	X			X	X	X	X	X	X
OK	Dec. 2020	X	X		X			X	X	
OR	Pending					X	X	X	X	X
PA	Oct. 2017	X				X	X	X	X	
RI	Jan. 2019	X	X					X	X	X
TN	Pending				X					X
UT	Nov. 2017	X						X	X	
VA	Dec. 2017	X	X			X		X	X	X
VT	Jan. 2017	X				X	X	X	X	X
WA	Jan. 2017	X				X	X	X	X	X
WI	Oct. 2018	X				X		X	X	
WV	Jan. 2018	X	X	X		X	X	X	X	

Appendix 2: ASAM Criteria for Placement Levels of Care



Appendix 3: ASAM Withdrawal Management Levels of Care

Level of Withdrawal Management for Adults	Level	Description
Ambulatory Withdrawal Management without Extended On-site Monitoring (Outpatient Withdrawal Management)	1-WM	Mild withdrawal
Ambulatory Withdrawal Management with Extended On-site Monitoring (Outpatient Withdrawal Management)	2-WM	Moderate Withdrawal
Clinically Managed Residential Withdrawal Management (Residential Withdrawal Management)	3.2-WM	Moderate withdrawal requiring 24-hour support
Medically Monitored Inpatient Withdrawal Management	3.7-WM	Severe withdrawal requiring 24-hour nursing care, physician visits as needed
Medically Managed Intensive Inpatient Withdrawal Management	4-WM	Severe, unstable withdrawal requiring 24-hour nursing care and daily physician visits

Appendix 4: Sample SUD Benefits Table Included in Most Waivers’ Special Terms and Conditions

*Sample obtained from the Special Terms and Conditions of the District of Columbia’s waiver.¹¹⁸

Table 1. SMI/SED and/or SUD Benefits Coverage Authorized with Expenditure Authority			
Benefit	Type	Medicaid Authority	Expenditure Authority
Outpatient services	SMI/SED and/or SUD	State plan (Individual services covered)	N/A
Intensive outpatient services	SMI/SED and/or SUD	State plan ¹ (Individual services covered)	N/A
Inpatient services	SMI/SED and/or SUD	State plan (Individual services covered)	Services provided to individuals in IMDs
Residential treatment services	SMI and/or SUD	Section 1115 demonstration	Services provided to individuals residing in IMDs
Medically Supervised Withdrawal Management	SUD	State plan (Individual services covered)	Services provided to individuals in IMDs
Medication-Assisted Treatment (MAT)	SUD	State plan (individual services covered)	Services provided to individuals in IMDs
Comprehensive Psychiatric Emergency Program	SMI and/or SUD	Section 1115 demonstration	N/A
Mobile Crisis Intervention and Outreach Services	SMI/SED and/or SUD	Section 1115 demonstration	N/A
Psychiatric Residential Crisis Stabilization Services	SMI/SED	Section 1115 demonstration	Services provided to individuals in IMDs

¹¹⁸ CMS, *supra* note 63, at 10–11.

Appendix 4: Sample SUD Benefits Table Included in Most Waivers’ Special Terms and Conditions (Cont.)

Table 1. SMI/SED and/or SUD Benefits Coverage Authorized with Expenditure Authority			
Benefit	Type	Medicaid Authority	Expenditure Authority
Recovery Support Services	SUD	Section 1115 demonstration	Services provided to individuals in IMDs
Psychosocial Rehabilitative Services	SMI	Section 1115 demonstration	N/A
Trauma-Informed Service: Trauma Recovery and Empowerment Model (TREM)	SMI/SED and/or SUD	Section 1115 demonstration	Services provided to individuals in IMDs
Trauma-Informed Service: Trauma Systems Therapy (TST)	SED	Section 1115 demonstration	N/A
Services of a Licensed Behavioral Health Practitioner	SMI/SED and/or SUD	Section 1115 demonstration	Services provided to individuals in IMDs
Transition Planning Services	SMI/SED and/or SUD	Section 1115 demonstration	Services provided to individuals in IMDs
Supported Employment	SMI	Section 1115 demonstration	N/A
Supported Employment	SUD	Section 1115 demonstration	N/A

Appendix 5: List of Acronyms

ASAM – American Society of Addiction Medicine

DSM – Diagnostic and Statistical Manual of Mental Disorders (5th edition)

EPSDT – Early and Periodic Screening, Diagnostic, and Treatment Benefit

FFP – Federal Financial Participation

IMD – Institutions of Mental Diseases

MAT – Medication-Assisted Treatment

OTP – Opioid Treatment Program

OUD – Opioid Use Disorder

SPA – Medicaid State Plan Amendment

SUD – Substance Use Disorder