Institutions for Mental Diseases (IMD) Exclusion and Substance Use Disorders: Lay of the Land[1]

Héctor Hernández-Delgado

Introduction

Since the inception of the Medicaid program, in 1965, the Medicaid Act has prohibited the use of federal financial participation (FFP) for services provided in Institutions for Mental Diseases (IMD). This long-standing statutory prohibition means that states have traditionally not been allowed to obtain FFP for services delivered in larger facilities designed for treatment of mental health or substance use conditions. States can, however, obtain FFP for mental health and substance use treatment provided in community-based settings and in smaller residential settings.

The IMD exclusion has been the subject of significant debate in recent years, as the U.S. grapples with an unabating overdose epidemic and substance use crisis. In response to calls to significantly weaken the exclusion as a way to address the ongoing crisis, the federal government has introduced two separate and, for all practical purposes, competing pathways for states to obtain FFP for services provided to Medicaid beneficiaries in IMDs.[1]

The first of these approaches is the use of section 1115 waiver authority to bypass the statutory prohibition on the use of FFP for services provided in IMDs. The first IMD 1115 waiver specific to SUD was approved by the Centers for Medicare and Medicaid Services (CMS) in 2015; today, approximately 35 states run similar waiver programs.[2] The second approach is a state plan amendment (SPA) option that Congress established as part of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 (or SUPPORT Act).[3] Under this provision states can elect to use FFP

[1] This issue brief incorporates extensive research from NHeLP interns Hayfa Ayoubi and Katherine Rhoude.

for IMDs for the duration of the congressional demonstration.[4] The option, which has only been pursued by three states, is set to expire in September 2023.[5]

This issue brief seeks to provide background on the purpose of the IMD exclusion and summarizes research demonstrating the lack of quality of SUD care typically provided in these large institutions. In addition, considering that the SPA option is set to expire later this year, the paper seeks to explain key policy differences between the SPA and 1115 options so that policymakers can make informed decisions regarding the state of SUD treatment in IMDs moving forward.

IMD Exclusion Background

An IMD is defined as "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."[6] The IMD exclusion prohibits states from using federal funds to pay for "care or services for any individual who has not attained sixty-five years of age and who is a patient in an [IMD]."[7] The IMD exclusion has served as an incentive for states to move away from large institutional residential facilities, which have historically provided ineffective care and treatment in deplorable conditions. Instead, by only providing FFP in smaller settings, Congress incentivized states to invest in community-based and outpatient behavioral health care, allowing patients to receive evidence-based care in more appropriate settings that respond to their needs.

While the statutory definition of IMDs is limited to "mental diseases," CMS has interpreted the exclusion to extend to facilities that provide inpatient or residential SUD services, as long as the care provided is "psychological in nature."[8] This interpretation is important because of how closely related SUDs and mental health conditions are. According to the National Institute on Drug Abuse (NIDA), 7.7 million adults in the U.S. have co-occurring mental health and substance use conditions (37.9% of all individuals with a SUD also have a mental health condition, and 18.2% of all individuals with a mental health condition also have at least one SUD).[9] As such, limiting the IMD exclusion solely to mental health conditions would create a significant loophole by virtue of which people with co-occurring MH/SUD conditions may still end up in large behavioral health institutions despite the exclusion.

There are populations and settings that are statutorily carved out of the IMD exclusion. First, the exclusion has always been limited to individuals under sixty-five. This means that FFP is available for services provided to older adults enrolled in Medicaid who are residents of an IMD. In addition, in 1972 Congress enacted the optional Medicaid benefit of inpatient psychiatric hospital services for individuals under age twenty-one.[10] States that elect to

provide this benefit may receive FFP for services provided in a subset of IMDs called Psychiatric Residential Treatment Facilities (PRTF), but these facilities and the services rendered must abide by strict federal standards that protect children and youth with behavioral health conditions from unnecessary institutionalization and against harm resulting from restrain and seclusion practices.[11]

In addition, only facilities with more than sixteen beds meet the definition of an IMD. States are still free to provide, and receive federal reimbursement for, services rendered to any resident (irrespective of age) of psychiatric and SUD facilities with sixteen beds or less. These services may be covered under various mandatory or optional Medicaid benefit categories, such as physician services, case management services, or other diagnostic, screening, preventive and rehabilitative services.

Quality of SUD Care in IMDs

Few studies have been conducted to evaluate the quality of SUD care provided in residential SUD facilities considered IMDs. However, the available evidence and news reports suggest that overwhelmingly residential SUD facilities with more than sixteen beds are not providing evidence-based and effective SUD care. While care must be individualized, there are certain treatment practices that are universally regarded as essential to effectively treat certain SUDs. For instance, treatment with the medications methadone and buprenorphine are considered, far and away, the gold standard for opioid use disorders (OUD), which have driven the overdose crisis for the better part of the last two decades. These medications for OUD (MOUD) may be combined with other behavioral health therapies, but their effectiveness is not contingent on availability of these other services.[12]

Unfortunately, many residential SUD facilities are not actively providing MOUD treatment to their patients. In a 2020 survey of residential OUD programs, only 29% of programs offered methadone or buprenorphine as opioid maintenance therapy and 21% actively discouraged its use.[13] Many facilities still discourage MOUD treatment with methadone and buprenorphine because they erroneously believe that this form of therapy entails the substitution of one chemical dependency for another, despite the fact that MOUD does not have the same effect on the brain as other drugs that create dependency and addiction and, in fact, help reduce the cravings and other harmful effects of OUD. Another survey of residential OUD facilities reported that only 34% of programs offer naltrexone (the least effective FDA-approved MOUD), 31% offer buprenorphine, and less than 3% offer methadone.[14] While it is expected that fewer facilities will be providing methadone for OUD onsite given federal requirements that restrict dispensing of methadone for OUD to opioid treatment programs (OTPs), there is

also little evidence that facilities are actively referring their residents to outside OTPs for methadone maintenance treatment.

Several news reports have also laid bare how difficult it is to access MOUD in residential settings. For example, a story published in *Vox* in September 2019 showcased the futile struggle of a young man in Vermont seeking effective SUD treatment in residential OUD facilities. This young man, named Sean Blake, entered eight residential treatment centers in a span of six years; five of these facilities have more than sixteen beds and likely qualify as IMDs.[15] During his stints in these facilities, Sean struggled to access medications, as most of his treatment centers did not offer, and sometimes actively discouraged, MOUD-based treatment. When a physician finally recommended medication, Sean resisted, in part due to the stigma he was exposed to at residential facilities. Sean died of an overdose at twenty-seven years old.

In another story, KFF Health News recently documented how BRC Recovery, a company that owns several residential SUD facilities in Texas and Tennessee, rakes in big profits by charging exorbitant fees for treatment that mostly consists of detoxification, weekly therapy sessions, and twelve-step group meetings.[16] These strategies are often used in combination with medication therapy but they should seldom be the first line of treatment for individuals with OUD. BRC Recovery facilities not only fail to offer MOUD treatment onsite or offer referrals to outside facilities providing MOUD, but they also actively discourage its use as an effective alternative because it is not considered a form of abstinence. BRC Recovery's residential facilities typically have more than sixteen beds, which means they would be classified as IMDs for Medicaid reimbursement purposes.[17]

Lack of MOUD is not the only evidence of substandard care in large residential SUD facilities. Studies have shown that these facilities do not regularly screen for co-occurring conditions that are common among individuals with SUD. In one of these analyses, only 55% of facilities reported conducting a tuberculosis screener, 42% reported testing for HIV, and just 31% reported testing for sexually transmitted diseases.[18] As an example of this concerning fact, most of the treatment facilities also failed to diagnose and treat Sean Blake's bipolar disorder, which made it virtually impossible for him to receive effective treatment that addressed the various needs that were contributing to or amplifying his OUD.

Moreover, anecdotal evidence reported in the media has highlighted the degree to which residents in SUD facilities are subjected to abusive practices. For example, in 2019 *Vox* published the story of Ian McLoone, who was in treatment for OUD at RS Eden, a 59-bed facility in Minnesota.[19] Ian recounted being forced to sit on a bench in silence for days as punishment for missing curfew, while being prohibited from attending group sessions or

lectures, or even talking to other patients. The facility also used confrontational counseling, which led to "shouting matches and nearly fist fights." These punitive and confrontational approaches have little supporting evidence and may actually hinder recovery.

Finally, evidence of sexual assault in residential SUD facilities have also been documented in various localities. In Southern California, which is often termed the "Rehab Riviera" for the proliferation of rehabilitation centers employing questionable recruitment and treatment practices, "the number one consumer complaint against rehab centers is related to sexual assault."[20] Sexual abuse in residential SUD facilities is heightened by the state of vulnerability in which many patients with SUD find themselves.

This lack of quality care in SUD facilities has not improved in states that have implemented section 1115 IMD waivers. For example, a recent study found that section 1115 SUD IMD exclusion waivers have not led to increased use of MOUD in residential SUD facilities despite the potential opportunity to expand access to the whole continuum of services.[21] Similarly, a CMS meta-analysis of Section 1115 IMD waivers concluded that even though many states change their SUD policies on paper to improve access to certain services, in practice states are not necessarily monitoring proper implementation of these new policies. With regards to MOUD, for example, "State officials reported variation in their ability to track whether residential facilities dispensed [MOUD] onsite on an ongoing basis. During interviews, state officials did not routinely discuss if they tracked whether residential facilities dispensed [MOUD] onsite within the facility."[22]

Legality of Approaches to Waive the IMD Exclusion

The IMD exclusion is a statutory provision of the Medicaid Act. Via the SUPPORT Act SPA option, Congress acted to change that statutory provision to allow states the option to cover services rendered in IMDs for Medicaid beneficiaries between 21 to 64 years old who have at least one SUD. This option expires in 2023. Because Congress enacted the IMD exclusion in the first place, it has the power to modify it as it sees fit, even if temporarily. Importantly, however, Congressional acts shed light on Congress' intent with regards to the future of the IMD exclusion and should help inform administrative action related to the exclusion.

While Congress can alter the IMD exclusion, the IMD exclusion cannot be waived administratively. Section 1115 gives the Secretary of HHS the authority to waive certain Medicaid requirements, but not the IMD exclusion. For the Secretary to approve a project pursuant to section 1115, the project must:

- be an "experimental, pilot, or demonstration" project;
- be likely to promote the objectives of the Medicaid Act;
- waive compliance only with requirements in 42 U.S.C. § 1396a; and
- be approved only to the extent and for the period necessary to carry out the experiment.

However, these waivers do not comply with the statutory requirements of section 1115 for two main reasons. First, the IMD exclusion provision is found in 42 U.S.C. § 1396d; that is, it is found outside of outside of 42 U.S.C. § 1396a, which contains the only provisions that the Secretary may waive under section 1115.

Second, while SUD-specific IMD exclusion waivers may have represented an experimental approach to addressing SUDs when they were first approved, states proposing the waiver renewals have failed to put forward a continuing hypothesis that requires an extension of the experiment. Congress envisioned section 1115 waivers as a tool for states to test novel approaches to health coverage that would then presumably inform congressional action. By continuing to approve section 1115 SUD-specific IMD waivers after Congress has created a statutory mechanism to obtain FFP for IMDs, HHS is effectively encroaching upon Congress' authority to enact long-term changes to the Medicaid statute.

Despite the illegality of these waivers, since 2016 CMS has approved thirty-five section 1115 demonstration projects that waive the IMD exclusion specifically for beneficiaries with SUD.[23] Many of those demonstrations, originally approved for five years, have been renewed for an additional five-year period.

Key Differences Between SUPPORT Act SPA Option and Section 1115 IMD Waiver Option

The SUPPORT Act SPA option and section 1115 waivers of the IMD exclusion differ in the conditions of participation that each policy imposes on states. Appendix A summarizes these differing policies, which are found in the statutory text in the case of the SPA option and, in the case of the section 1115 waiver option, in two guidance letters and in the terms and conditions of approved waivers.[24]

One of the most significant differences between the two policies is the maximum length-of-stay that is allowed in an IMD. The SUPPORT Act SPA option is clear that FFP is only available for stays up to thirty days in a span of twelve months.[25] The rationale behind this policy is to incentivize states to ensure that beneficiaries stay in these large institutions for the least

amount of time necessary and that they are timely transitioned to less-intensive levels of care on an outpatient basis and in their communities. Because states have to pick up the full cost post-30 days, the maximum length-of-stay heightens the state's incentive to discharge anyone who is ready to leave the facility, and to facilitate access to community-based services.

The first section 1115 IMD waivers for SUD that CMS approved also included maximum lengths-of-stay of thirty days.[26] However, CMS' current policy only requires states to commit to achieving an average statewide length-of-stay of thirty days.[27] An average length of stay in aggregate, as opposed to a cap on days per person, will mean that some individuals will stay in a facility for significantly longer than 30 days. Some outliers may be in facilities for extremely long periods of time—which often happens because of barriers to discharge, such as a lack of housing, lack of community-based services, or even lack of transportation.

Another key difference relates to requirements around availability of MOUD in IMDs. The SPA option requires states to ensure that participating IMDs offer at least one opioid agonist medication (either methadone or buprenorphine) and one opioid antagonist medication (naltrexone) onsite.[28] The section 1115 waiver option, on the other hand, requires IMDs to either offer onsite or provide referrals to other facilities that are able to provide the three MOUDs approved by the FDA.[29] Allowing IMDs to comply with the MOUD requirement by making referrals to outside facilities increases the availability of methadone maintenance treatment given that few IMDs are also OTPs and able to dispense methadone under federal law. However, the SPA option requirement to provide MOUD onsite may increase the likelihood that IMDs provide evidence-based SUD treatment rather than the subpar care many of them currently provide. Regrettably, neither option requires states to monitor MOUD intake among IMD residents with SUD.

Considering the high number of facilities that actively discourage MOUD use, a more appropriate quality measure may be to require affirmative state action when merely offering MOUD has not led to increases in MOUD utilization. For example, the federal government could require states to add MOUD-specific requirements to the process of licensing, license renewal, and other residential provider standard governed by state law. Some states have added such residential standard requirements via section 1115 and have included requirements to do mandatory trainings, develop written plans for providing MAT access, prohibit providers from discriminating against beneficiaries receiving MAT, and require providers to inform beneficiaries about all their options for MAT.[30] In addition, states could (and the federal government should require them to) incorporate tracking and monitoring of MAT availability, offering, and uptake into their regular audits of residential facilities.

A third policy difference between the two options revolves around maintenance of funding levels for community-based SUD services, which seeks to help mitigate the effect of increased IMD bed availability. When more residential beds are available, they will be filled, inevitably pulling resources away from community-based services.[31] To counterbalance that effect, both SPA and section 1115 options require states to maintain certain levels of funding for community-based SUD services. However, the two policies differ in subtle but important ways. While the section 1115 waiver option prohibits states from diverting community-based funding to the new IMD services, the SPA option explicitly requires states to maintain or expand the level of funding they had allocated to the same SUD services in the community on the year prior to the enactment of the SUPPORT Act.[32] These differences are important because, whereas the section 1115 waiver policy allows states to reduce funding for community-based services as long as the funding is not being redirected to IMD services, the SPA option, at least in theory, imposes a hard floor on the level of funding for community-based SUD services.

While the mechanisms for ensuring continuous availability of resources for community-based services differ between the SPA and section 1115 options, the reality is that none has proven to be particularly effective. In many states, community-based SUD (and mental health) services continue to be underfunded and beneficiaries often have to rely on residential institutions to access services they could receive in their communities. While the SPA option maintenance of effort provision is stronger than that required through section 1115, the statute defers to HHS the authority to "establish a process for States to report…such information as the Secretary deems necessary to verify a State's compliance" with the maintenance of effort requirement.[33] To date, HHS has not released detailed guidance about what such reports must contain.

Regardless of which vehicle policymakers endorse or states use for increased funding for IMD services, maintenance of effort policies should, at a minimum, require states to report the following information stratified by diagnosis, race, sex, ethnicity: 1) the percentage of individuals who access MAT while in an IMD, 2) the percentage of individuals who continue use of MAT while in an IMD, and 3) the percentage of individuals who are discharged with a MAT provider. In addition, states should be required to submit information about availability and usage of all SUD community-based services (either required by federal law or covered at the state option) on a monthly basis for the duration of the SPA or demonstration.

A final difference between the two options is the quality measures that states are required to evaluate and report on. While the SUPPORT Act is silent as to specific measures to ensure a minimum level of quality in IMD facilities, CMS has added reporting requirements on: Increased Rates of Identification, Initiation and Engagement in Treatment; Improved Adherence to Treatment; Reduction in Overdose Deaths Particularly Those Due to Opioids;

Reduced Utilization of Emergency Department and Inpatient Hospital Settings; and Fewer Readmissions to the Same or Higher Level of Care for Improved Access to Care for Co-morbid Physical Health Conditions among Beneficiaries. CMS has enforced this reporting requirement inconsistently and there is little evidence that the existence of this requirement has led to better care in these facilities. On the SPA side, the statute allows the Secretary of HHS to implement quality measures requirements, but guidance put out by the agency thus far has not implemented any such requirements.

Conclusion

In 2023, Congress will need to decide whether to extend the SUPPORT Act's SPA option for services rendered to Medicaid beneficiaries with SUD ages twenty-one to sixty-four residing in IMDs. Before making that decision, policymakers should understand that the *status quo* created by both the SPA option and section 1115 waivers has been less new investment in community-based SUD care and more availability of SUD treatment settings that provide subpar care to patients who may not necessarily need that level of intervention and supervision in the first place. In addition, policymakers should know the key policy differences between the SUPPORT Act SPA option and the section 1115 waiver option in order to understand the policies that have contributed to the lack of investment of community-based services and to the proliferation of Medicaid-participating facilities that are not providing high quality, evidence-based SUD care. Moving forward, decisions must be taken with the overall goal of incentivizing states to ensure availability of effective SUD services in settings that represent the least amount of intervention needed and proper and timely transitions to lower levels of care.

Appendix A: Summary of Policy Differences Between SUPPORT Act SPA Option and Section 1115 Waiver Option

Category	**Section 1115 Waiver**	**SUPPORT Act SPA**
Type	CMS Waiver/Administrative	State Plan Option/Legislative
Authority	CMS, Dear State Medicaid Director Letter # 17-003	SUPPORT Act, Pub. L. No. 115-271 § 5052, 42 U.S.C. § 1396n(l). CMS, Dear State Medicaid Director Letter # 19-0003
Length of program	5 years	For the period beginning on October 1, 2018, and ending on October 1, 2023
Prerequisite	• Outline its strategy for achieving the goals of the demonstration • Must use evidence-based patient assessment and placement criteria and provide access to MAT.	• Notify the Secretary of how it will ensure evidence-based clinical screening • Must follow evidence-based practices, including clinical screening and MAT (MAT must be accompanied with behavioral health services). • Must make available at least two forms of MAT onsite, including one agonist (buprenorphine or methadone) and one antagonist (naltrexone). IMDs are allowed (but not required) to offer other medications offsite.
Outpatient level of care	Must cover outpatient and intensive outpatient services within 12 to 24 months of demonstration approval	Must cover all 4 outpatient levels of care (early intervention; outpatient services; intensive outpatient services; partial hospitalization)
Inpatient level of care	Must cover intensive inpatient/residential and medically supervised withdrawal management within 12 to 24 months of demonstration approval	Must cover at least two of the following residential and inpatient levels of care: • Clinically managed low-intensity residential services; • Clinically managed, population specific, high-intensity residential services for adults; • Clinically managed, medium-intensity residential services for adolescents; • Clinically managed, high-intensity residential services for adults; • Medically monitored, high-intensity inpatient services for adolescents;

		• Medically monitored, intensive inpatient services withdrawal management for adults; and • Medically managed intensive inpatient services.
Length of Stay	Varies by waiver: some numeric day limits, some unspecified, some require a 30-day statewide average. Requirements per CMS guidance: • Pre-Nov. 2017: For short-term residential treatment in IMDs, stays will be limited to an average length of stay of thirty (30) days in • Post-Nov. 2017: average lengths of stay (LOS) in residential treatment aiming for a statewide average LOS of 30 days.	30 days in a 12-month period
Care transitions	• Require IMDs to provide services at lower levels of clinical intensity. • Develop policies to link residential patients to community-based services.	• Ensure that placement in IMD would allow for an eligible individual's successful transition to the community. • Ensure that all IMDs are either (a) able to provide care at a lower level of clinical intensity; OR (b) have an established relationship with another facility that is able to provide lower level of clinical intensity.
Funding Levels	Maintain current funding levels for a continuum of services. Pre-November 2017: • Funding should be consistent with SAMHSA's maintenance of effort requirements for its Substance Abuse Prevention and Treatment Block Grant. • Availability of this funding should not divert state spending on mental and substance use disorder service. Post-November 2017: • Availability of this funding should not divert state spending on mental and substance use disorder service.	Maintain on an annual basis a level of funding expended by the State not less than the level of such funding for items and services furnished to individuals who are patients in eligible IMDs and eligible individuals in community-based settings for the most recently ended fiscal year prior to the enactment of the SUPPORT Act.

Quality Measures	• States must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E • States must ensure SUD treatment providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107 • States must report on the following quality measures: - Increased Rates of Identification, Initiation and Engagement in Treatment - Improved Adherence to Treatment - Reduction in Overdose Deaths Particularly Those Due to Opioids - Reduced Utilization of Emergency Department and Inpatient Hospital Settings - Fewer Readmissions to the Same or Higher Level of Care for - Improved Access to Care for Co-morbid Physical Health Conditions among Beneficiaries	No specific quality measures required to date.

ENDNOTES

[1] States that provide services via managed care are permitted to pay capitated rates to managed care organizations (MCOs) for individuals who are in IMDs for less than 15 days per month. MCOs cover services provided in IMDs via "in lieu of" authority. 42 U.S.C. § 1396b(m)(7); 42 C.F.R. § 438.6(e). "An in-lieu of service is a service that is not included under the state plan, but is a clinically appropriate, cost-effective substitution for a similar, covered service." MACPAC, Payment for services in institutions for mental diseases (IMD), https://www.macpac.gov/subtopic/payment-for-services-in-institutions-for-mental-diseases-imds/ (last visited June 30, 2023). At least 32 states allow MCOs to cover services for adults age 21-64 in IMDs using "in lieu of" authority. Report to Congress, Study and Report Related to Medicaid Managed Care Regulation (Jan. 25, 2022), https://www.medicaid.gov/medicaid/managed-care/downloads/rtc-cures-act-12002.pdf. Many states use both "in lieu of" authority and section 1115 waivers together. *Id.*

[2] Kaiser Family Found., Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State, Medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table4 (last visited July 12, 2023).

[3] Pub. L. No. 115-271, 132 Stat. 3894, 3971.

[4] 42 U.S.C. § 1396n(l).

[5] For more information in how CMS has implemented the SPA option and additional guidance, see CMS, Dear State Medicaid Director Letter (Nov. 6, 2019) (SMD # 19-0003), https://www.medicaid.gov/federal-policy-guidance/downloads/smd19003.pdf.

[6] 42 U.S.C. § 1396d(i).

[7] 42 U.S.C. § 1396d(a)(B).

[8] *See* CMS, State Medicaid Manual § 4390, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.

[9] NIDA, Comorbidity: Substance Use and Other Mental Disorders (Aug. 15, 2018), https://nida.nih.gov/research-topics/comorbidity/comorbidity-substance-use-other-mental-disorders-infographic.

[10] 42 U.S.C. § 1396d(a)(16) and (h).

[11] 42 C.F.R. § 441.151(a)–(b).

[12] Sarah E. Wakeman et al., *Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorders*, 3 JAMA e1920622 (2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032.

[13] 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.

[14] Maureen T. Stewart et al., Dep't of Health & Human Servs., Assistant Sec'y for Plan. & Evaluation, *State Residential Treatment for Behavioral Health Conditions: Regulation and Policy Environmental Scan* (2019), https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//192871/BehHeaConLR.pdf.
[15] German Lopez, *She spent more than $110,000 on drug rehab. Her son still died.*, Vox (Sept. 3, 2019), https://www.vox.com/policy-and-politics/2019/9/3/20750587/rehab-drug-addiction-treatment-sean-blake-opioid-epidemic.
[16] Renuka Rayasam & Black Farmer, *Some Addiction Treatment Centers Turn Big Profits by Scaling Back Care*, Kaiser Health News (Jan. 31, 2023), https://khn.org/news/article/some-addiction-treatment-centers-turn-big-profits-by-scaling-back-care/.
[17] Other stories have found similar problems in other large residential SUD facilities. *See e.g.*, Brianna Ehley & Rachel Roubein, *'I'm trying not to die right now': Why opioid-addicted patients are still searching for help*, Politico (Jan. 22, 2019), https://www.politico.com/story/2019/01/20/opioid-treatment-addiction-heroin-1088007 (describing a residential treatment program that shunned MAT); German Lopez, *We have a solution for the opioid epidemic. It's dramatically underused*, Vox (Dec. 17, 2019), https://www.vox.com/policy-and-politics/2019/12/17/18292021/opioid-epidemic-methadone-buprenorphine-naltrexone-drug-rehab (describing a 59-bed residential treatment facility that pushed a resident to stop taking methadone).
[18] Stewart et al., *supra* note 14.
[19] William L. White & William R. Miller, *The use of confrontation in addiction treatment: History, science and time for change*, 8 COUNSELOR 12 (2007), https://www.chestnut.org/Resources/3735f9d7-e5c9-4174-93bb-793638b0bc18/2007ConfrontationinAddictionTreatment.pdf.
[20] Tony Saavedra, *So-called 'Rehab Mogul' raped women, dealt drugs in treatment centers*, Orange Cty. Register (Feb. 26, 2018), https://www.ocregister.com/2018/02/26/la-oc-rehab-mogul-convicted-of-sexually-exploiting-patients-and-offering-them-drugs/. For more stories about sexual abuse allegations in residential SUD facilities, see Lauren Chooljian, *He built New Hampshire's largest addiction treatment center. Now, he's accused of sexual misconduct*, WBUR (Mar. 27, 2022), https://www.wbur.org/news/2022/03/27/eric-spofford-granite-recovery-centers-sex-abuse-allegations (describing allegations from patients and staff of sexual assault by CEO of 88-bed residential treatment facility).
[21] Johanna Catherine Maclean et al., *Institutions for Mental Diseases Medicaid Waivers: Impact on Payments for Substance Use Treatment Facilities*, 40 HEALTH AFF. 326 (2021).

[22] CMS, *Medicaid Section 1115 Substance Use Disorder (SUD) Demonstrations: State Experiences Expanding Availability of Medication Assisted Treatment for Beneficiaries in Residential Settings* (2022), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/sud-1115-rcr-availability-mat.pdf.
[23] *See* Kaiser Fam. Found., Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State (June 23, 2023), https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/. For more information about SUD-specific section 1115 IMD exclusion waivers, see Cathren Cohen, Héctor Hernández-Delgado, & Alexis Robles-Fradet, *Medicaid Section 1115 Waivers for Substance Use Disorders: A Review* (2021), https://healthlaw.org/resource/medicaid-section-1115-waivers-for-substance-use-disorders-a-review/.
[24] The SPA authority can be found on SUPPORT Act, Pub. L. No. 115-271 § 5052, 42 U.S.C. § 1396n(l). The administrative guidance regulating section 1115 SUD-specific IMD exclusion waivers are: CMS, Dear State Medicaid Director Letter (July 27, 2015) (SMD # 15-003) [hereinafter SMD 15-003], https://www.medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf; and CMS, Dear State Medicaid Director Letter (Nov. 1, 2017) (SMD # 17-003) [hereinafter SMD 17-003], https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf.
[25] 42 U.S.C. 1396n(l)(2).
[26] SMD 15-003, *supra* note 24, at 12. To our knowledge, CMS did not strictly enforce this maximum length-of-requirement.
[27] SMD 17-003, *supra* note 24, at 10.
[28] 42 U.S.C. 1396n(l)(7)(C)(ii).
[29] SMD 17-003, *supra* note 234, at 9.
[30] CMS, *supra* note 22.
[31] *See* Martha Shumway et al., *Impact of Capacity Reductions in Acute Public-Sector Inpatient Psychiatric Services*, 63 Psychiatric Services 2 (2012), https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201000145.
[32] 42 U.S.C. 1396n(l)(3); SMD 17-003, *supra* note 24, at 2. The section 1115 waiver policy does encourage states to maintain funding levels for community-based services, but it falls short of requiring such maintenance of effort like the SPA option does.
[33] 42 U.S.C. § 1396n(l)(3)(C).