Tracking Health Reform

Section 1115 Substance Use Disorder Waivers: Opportunities and Limitations

Thomas Statchen
Harold Pollack
University of Chicago

Amanda J. Abraham
University of Georgia

Christina M. Andrews
University of South Carolina

Colleen M. Grogan
University of Chicago

Abstract

In 2022, 48.7 million people in the United States (17.3% of the population aged 12 or older), met criteria for substance use disorder (SUD). Nearly 40% of people with opioid use disorder (OUD) are Medicaid recipients, making Medicaid the largest single source of OUD treatment insurance coverage. Despite this crucial importance, there remain two major barriers to expanding access to treatment for persons with SUD baked into the program: the Institutions for Mental Diseases (IMD) exclusion and the Medicaid inmate exclusion. In this essay we first provide a timeline of these two waiver reforms to illustrate the variation in waivers over time and across states. Second, we assess the evidence to date on how well the SUD waivers are working to accomplish these goals in states that have adopted them. This review will focus on the SUD waivers that address the IMD exclusion, because the MIE waivers are too new for any systematic evidence. We will then consider outstanding implementation challenges and policy risks associated with the IMD and MIE waivers, and conclude by considering challenges these waivers do not address and therefore demand particular attention to properly serve persons living with SUD.

Keywords Medicaid, Section 1115 waivers, substance use disorder

The plurality of Americans living with substance use disorder obtain health insurance from Medicaid. However, due to a provision in Medicaid dating back to its inception, the Institutions for Mental Disease (IMD) exclusion, the program cannot fund residential treatment for substance use disorder, despite this modality being part of the American Society of Addiction Medicine's spectrum of care. For this reason, policymakers and advocates have long considered removing,

Forthcoming in an issue of *Journal of Health Politics, Policy and Law*. *Journal of Health Politics, Policy and Law* is published by Duke University Press. DOI: 10.1215/03616878-12166733.

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

altering, or waiving the IMD exclusion policy. In the last 10 years, IMD exclusion waivers have become widespread, with 37 states having implementing them and additional pending waivers. Although waiving the IMD exclusion specifically addresses residential care, all approved waivers include the goal of increasing access to other essential SUD treatments, and many also attempt to transform the delivery system to reduce fragmentation and increase coordination of care. Here, we aim to briefly review the history of the IMD exclusion and IMD exclusion waivers, analyze the current evidence on their efficacy, and identify the challenges and opportunities that have emerged from their implementation and evaluation thus far.

Background: The Opioid Epidemic and the Promise of Waivers

According to the most recent data, nearly 64,000 Americans died of an opioid overdose in 2023 (National Center for Health Statistics, 2025). Access to affordable and easily accessible substance use disorder (SUD) treatment is a key tool to address this overdose epidemic. The American Society of Addiction Medicine has established a continuum of care that is widely utilized to define levels of care within addiction medicine, including outpatient, residential, and inpatient. Across all levels of care, three FDA-approved medications - methadone, buprenorphine, and injectable naltrexone—have repeatedly proved to be efficacious in reducing fatality rates and helping people with OUD move toward recovery (Koehl, Zimmerman, and Bridgeman 2019).

Yet despite significant evidence that medications for OUD (MOUD) are effective, only a small minority (22%) of persons living with OUD receive MOUD, despite guidelines recommending its use for treatment of OUD (Jones et al. 2023). There are many factors that influence people's likelihood of receiving medication to treat OUD. MOUD hesitancy is

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

sometimes driven by the viewpoint that taking such medications simply replaces one addiction with another and consequently does not represent "true" recovery (Slocum, Paquette, and Pollini 2023). There is also hesitancy to prescribe MOUD among some providers and some SUD treatment centers promote abstinence-only (non-medication) treatment models (Cioe et al. 2020; Kennedy-Hendricks et al. 2024). In addition, federal and state policies can have an enormous influence on providers' willingness to prescribe MOUD, and patients'ability to obtain it. As is almost always the case in access to health care services, provider and facility supply (or lack thereof) and health insurance status play a significant role in shaprng access to SUD treatment. Restrictions in state's Medicaid benefits and utilization policies have been shown to be associated with decreased number of Medicaid-insured patients engaged in treatment (Andrews et. al, 2019).

In response, several national policy reforms have been implemented to expand MOUD treatment access and utilization. To enhance the prescription and availability of MOUD, the federal government eliminated the X-waiver requirement, passed in 2000, which first allowed physicians to prescribe buprenorphine for OUD treatment but required prescribing physicians to have special certification which was thought to prevent many providers from prescribing buprenorphine due to the ornerous certification process (LeFevre et al. 2023). Evidence regarding the practical impact of removing this waiver is mixed (Paiva et al. 2024; Roy et al. 2024; Chua et al. 2024; Jones, Olsen, et al. 2023). Removal of the X-waiver has attracted new prescribing clinicians, but this expansion is largely concentrated in emergency and urgent-care settings (Jones, Olsen, et al. 2023).

The Affordable Care Act's Medicaid expansion strengthened the program's centrality to addiction policy. For years, Medicaid imposed a series of categorical eligibility restrictions (e.g.,

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

the recipient had to be a child, a parent, or live with a qualifying disablility), which meant that single non-disabled adults were ineligible. SUDs are specifically excluded as qualifying conditions for the nation's two main disability programs: Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). Since 2014, Medicaid expansion has proved especially important for adults who experience SUD, who can now qualify for Medicaid based solely on their income. Today, 40 states plus the District of Columbia have adopted the Medicaid expansion and nearly 40% of people with OUD are Medicaid enrollees, making Medicaid the largest payment source for OUD treatment (Saunders and Gifford 2024). Medicaid is a central lever through which treatment for OUD can be improved.

While Medicaid undoubtedly plays a central role in financing OUD, and more broadly SUD treatment (e.g., addictions for alcohol, stimulants), several policies restrict the program's ability to expand access to care. Principal among these is the Institutions for Mental Diseases (IMD) exclusion, which prevents federal Medicaid reimbursement for any residential treatment services for addiction or psychiatric care, preventing payments to "institutions with more than 16 beds that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases other than dementia or intellectual disabilities." (Dixon and Goldman 2019). The IMD exclusion was originally introduced in the 1965 law that created Medicaid to address systematic, often harmful over-reliance on institutional settings for addiction and mental health care. The exclusion sought to support short-term stabilization and community-based treatment for SUD. Yet in doing so, it has resulted in systematic restrictictions in access to residential treatment for SUD.

Residential care is a key component of the ASAM continuum of care, providing intensive care and 24-hour support for individuals with severe and complex SUD, often

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

complicated by social factors (de Andrade, 2019). Patients in residential treatment settings are more likely to be non-Hispanic White, male, and living an urban area, with comorbid conditions also more frequently observed (Allen et. al, 2023). Benefits of residential care include the structured nature of the programs, monitored detoxification due to no-drug-or-alcohol policies, and the opportunity to receive care away from spaces that might be associated with prior opioid use (Allen et. al, 2023). The expansion of availability of residential care has been a major focus for policymakers, despite mixed evidence of the quality of residential care (Beetham et. al, 2021). A systematic review from 2019 found moderate quality evidence for the effectiveness of residential treatment in improving outcomes within a variety of SUD and life domains (de Andrade, 2019). However, it also noted limitations of study quality, most often due to high rates of attrition and large variations in length of stay within treatment. In 2020, Wakeman et. al. found that residential treatment was not associated with significant improvement in outcomes for patients with SUD (Wakeman et. al, 2020). Despite mixed evidence, it remains an important goal to expand access to the full ASAM continuum of care for all individuals living with OUD.

In 2015, the Center for Medicaid and Medicare Services (CMS) issued guidance offering the opportunity to waive the IMD exclusion, often simply referred to as SUD waivers, utilizing the Section 1115 Waiver process (CMS 2015). Below we follow the bulk of literature and also refer to these waivers that waive the IMD exclusion as SUD waivers. Largely driven by the need to respond more comprehensively to the opioid epidemic, more than 30 states have received waiver approval (KFF). There is enormous interest in SUD waivers because they are also intended to ensure broader delivery model reforms beyond reimbursement of residential care. Another central goal of SUD waivers is to increase

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

access to MOUDs, and to ensure robust person-centered community-based care once patients are discharged from residential treatment settings. States receiving waivers were originally required to expand access to MOUDs through Medicaid-funded residential treatment, and, since 2020, MOUD has been a required benefit of all Medicaid programs with or without waivers.

In this essay, we assess the evidence to date on how well the SUD waivers are working to accomplish these goals in states that have adopted them. We also present the outstanding implementation challenges and policy risks associated with SUD waivers, and conclude by considering challenges these waivers do not address and therefore demand particular attention to properly serve persons living with SUD.

[Table 1 about here]

Timeline of Waivers

IMD exclusion waivers have been offered at various points over the last 30 years. From 1993 to 2009, nine states had active waivers allowing for reimbursement of SUD treatment delivered in at IMDs (CRS 2023). Limited research was conducted on these waivers; so their impacts are unclear. All but one of these waivers were phased out in 2009.

In 2015, the Centers for Medicare and Medicaid Services (CMS) released guidance encouraging states to apply for IMD exclusion waivers focused on improving SUD treatment. This guidance focused heavily on "broad and deep" transformation of behavioral healthcare systems within states, with multifaceted goals encompassing recovery coaching, identification of individuals with SUD, coordination with primary care, and strategies to better evaluate care, amongst others (CMS 2015). While loosening the IMD exclusion is an important aspect of the guidance, permitting patients access to the full spectrum of "comprehensive evidence-based

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

benefits," it is just one of many priorities targeted in the waiver. Yet in terms of pathways opened to states to provide care, the IMD exclusion is the only new federal financial participation (FFP) opportunity opened by the waiver. This renders the IMD exclusion the primary focus of CMS guidance. However, CMS guidance lays out clear requirements to ensure expanded residential care permitted within the waivers is used to "supplement and coordinate with," rather than supplanting, community-based care (CMS 2015). Eight states responded to this guidance with approved waiver proposals between July 2015 and November 2017.

On November 1, 2017, CMS released updated guidance that appeared to streamline the waiver process. In the guidance, they describe this as a response to a March 14, 2017 letter from the Trump Administration seeking "additional opportunities for states to provide a full continuum of care for people struggling with addiction" and "a more streamlined approach for section 1115 substance abuse treatment demonstration opportunities." (CMS 2017). As Cohen et al. (2021) has noted, this guidance removed language focused on transformation and care coordination, and instead focused more specifically on the IMD exclusion (Cohen, Hernández-Delgado, and Robles-Fradet 2021). The guidance is significantly shorter than the previous version, and, while still supportive of the idea of supplementation and coordination, includes less specific requirements. The rate at which states applied for waivers increased significantly following this streamlined guidance, with close to 30 waivers approved since 2017. The guidance has not been updated since 2017, though approvals and renewals continue.

Consistent with changes in guidance, the content of many of the approved SUD waivers changed from a pre-2017 focus on more comprehensive benefits and reorganizing the SUD delivery system, to waivers focused on limited benefit changes primarily providing coverage for residential treatment. Crable et al. (2022) classified three of five waivers (California, New

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhppl/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

Jersey, and Virginia) as comprehensive delivery model reforms during the 2015-2016 approval period, compared to the post-2017 period where 15 of 24 waivers focused on limited benefit changes (E. Crable, Jones, et al. 2022).

While there is evidence of this pattern pre- and post-CMS guidance reform, SUD waivers are complex because they are overlaid on top of existing state Medicaid programs, which vary in comprehensiveness of SUD coverage across the states. Some states already offered coverage of residential care via block grants to facilities or had previously implemented broad system reform, leading them to focus on more narrow changes in their SUD waiver. Other states used waivers for larger systemic changes. Nonetheless, access to residential treatment is the most common theme across all waivers, with access to peer recovery coaches being another commonly cited change. The introduction of peer recovery coaches represents an effort to improve community support and care coordination across the treatment spectrum, and especially upon discharge from residential settings.

All states with approved SUD waivers are also required through the original guidance to implement access to MOUD concurrent with residential treatment for SUD. Care coordination—beyond use of peer recovery coaches—is another focus of waiver guidance, but the way states attempt improvement in care coordination varies substantially across SUD waivers. For example, some states utilized the waiver as an opportunity to expand other facets of the care continuum, such as intensive outpatient treatment services for SUD.

SUD Waiver Evidence

The primary finding across preliminary studies is unsurprising: IMD waivers increase residential care receipt among Medicaid enrollees. For example, Maryland experienced an increase in the

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

UNEDITED MANUSCRIPT

percent of enrollees with OUD receiving residential care from 2.4% to 8.6%, two years following implementation of the waiver (Cunningham et al. 2020). A study of California's IMD waiver found a 25% overall increase in residential treatment admissions (of all insurance types) following waiver implementation, with no change in admissions to other types of treatment modalities including outpatient programs or opioid treatment programs (Bass et al. 2023). This makes sense; if facilities are able to be reimbursed through Medicaid for a service, it is more likely that they will accept and treat patients with that insurance. However, the stated goals of these waivers are broader than just permitting access to residential treatment – they focus on systems change, improved access to community-based treatment and MOUDs, and overall reduction in OUD and associated harms such as overdose.

The impact of waivers on these broader goals is less clear. Most studies show that SUD waivers with more comprehensive reforms were able to increase MOUD access, whereas SUD waivers with limited benefit changes show no difference in MOUD takeup (Cunningham et al. 2020 (Cunningham et al. 2020; Sugarman, Li, and Saloner 2024; Lindner et al. 2024). For example, Virginia experienced a doubling in the rate of MOUD treatment for OUD per 1000 Medicaid member months in the two years following implementation of their SUD waiver, and Louisiana experienced a tripling of MOUD use statewide amongst Medicaid enrollees diagnosed with OUD over a similar period following waiver implementation (Sugarman, Li, and Saloner 2024). Both of these SUD waivers were implemented alongside broader comprehensive policy changes. In contrast, Maryland found no impact from their SUD waiver implementation on MOUD use (Cunningham et al. 2020). Cunningham et al. (2020) argue that Maryland's restricted waiver is a key explanation. However, labeling Maryland's waiver as "restricted," while technically true is a bit misleading because the state implemented significant changes to their

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

SUD treatment delivery system in 2012, which explains why Maryland submitted a much more limited waiver in 2016, and might also explain the lack of impact following 2016 if impacts occurred post-2012 and prior to 2016.

Two more recent studies also support these findings. First, a study of 9 states post 2017 found no changes in the proportion of residential treatment programs offering MOUD or operating an opioid treatment program over the two years following waiver implementation (Maclean et al. 2021). While additional people entering residential treatment may result in more use of MOUD, the study did not find that the residential centers themselves responded to the waivers as there was no increase in probability that a given residential program offered MOUD treatment, possibly due to the pervasive underuse of these medications. Combatting this underuse appears to be a focus of SUD waivers, but these results appear to show they may not be affecting this particular outcome. The same study did find that there was a moderate increase in the proportion of outpatient facilities offering MOUD, perhaps pointing to desired, systemic outcomes of the waivers, refracted through the different preferred treatment approaches within residential and outpatient care (Maclean et al. 2021).

Second, Lindner et al. (2024) conducted the first multi-state analysis of Medicaid claims data, which analyzed 17 states which received IMD exclusion waivers between 2017 and 2020. Within this study, waiver implementation was not associated with an overall increase in any MOUD treatment receipt in the states. It was however, associated with a small (2.3%) increase in methadone use, but this increase disappeared when concurrent changes in state Medicaid program coverage of methadone were accounted for in models. Of note, changes to coverage in methadone can be implemented by state Medicaid programs with or without an SUD waiver. Further, the study did find an increase in any MOUD among Medicaid enrollees diagnosed with

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

severe OUD who had an inpatient or residential stay, which suggests that SUD waivers might be improving linkages to MOUD through residential care. This indicates that there is potential for residential treatment waivers as an incentive to encourage states to expand access to MOUD, but residential treatment itself is not a significant driver of this treatment. Finally, when Lindner et al. broke down the study results by early, intermediate and late-waiver adopting states, the increase in any MOUD treatment effect only held for the early waiver adopting states such as Louisiana and Virginia. Similar to previous studies noted above, the authors hypothesize that this could be due to more expansive reforms in those waivers, and in fact, some of them were developed and approved prior to the change in guidance that de-emphasized systemic change.

Another consideration in the success of waivers is whether they are able to change the supply of specialty SUD treatment providers, whether that be residential, inpatient, or community-based. All states face shortages of these providers, contributing to long wait times and difficulty accessing treatment (Cunningham et al, 2020). The ability to bill Medicaid for residential treatment, along with the other systems-level changes in the more transformational waivers, might be expected to spur the opening of additional SUD providers in subsequent years. However, to date, this has not been the case. Cunningham and colleagues' study of Maryland and Virginia found that while in Virginia the number of SUD treatment providers accepting Medicaid increased, there was no overall increase in the number of providers in either state (Cunningham et al. 2020). Providers interviewed in this study highlighted the continued shortages and resulting wait times as a significant burden. The broader analysis of nine states similarly found no consistent changes in the overall number of residential treatment providers (Maclean et al. 2021).

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

Finally, a major focus of waiver guidance has been on improving coordination and reducing fragmentation of care. This focus has been less widely studied, with only one paper reporting results related to fragmentation. The analysis of Virginia and Maryland found qualitatively that leaders and providers in those states continued to report significant fragmentation following waiver implementation (Cunningham et al. 2020). This is an important potential line of further research to better understand the impact of waivers on coordination of care.

Several factors likely drive these differential results in waiver impact between states. One is the distinction between Medicaid reforms already executed through state authority and those made utilizing waivers. As described above, Maryland had already implemented many reforms through state authority in 2012, prior to waiver adoption (Cunningham et al. 2020). This meant that their waiver did not involve systems change beyond the permission to utilize residential care. As a result, while residential care increased due to the waiver, MOUD barely changed. States can utilize their state plan amendments to create transformative reform. Further, comprehensive Medicaid benefit coverage policies still matter even when states adopt the SUD waiver--ensuring not only the ability to access residential care but also potentially the full spectrum of ASAM recommended levels of care.

Second, while residential care and MOUD coverage and emphasis are common, there are otherwise large variations in waiver program design across time and between states. Some of the null findings around change in MOUD usage might be attributable to this variation washing out the effect of waivers with more transformative policy designs (Cohen, Hernández-Delgado, and Robles-Fradet 2021) This pattern highlights the challenges in comparing waiver to non-waiver states—comparisons that assume homogeneity among waiver states. There is the strong

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

possibility that other state Medicaid policies (e.g., differences in requirements around benefit coverage or prior authorization and other coverage limitations) may be more important to the improvement of care than the IMD exclusion that is common across all waiver states.

Finally, contexts within states matter for both whether a state will adopt a waiver and for its impact. Many contextual factors influence whether a state adopts a waiver, including the ownership status of residential treatment facilities. For example, waiver adoption appears more common in states with a larger proportion of for-profit treatment facilities (Ge, Romley, and Pacula 2024). Indeed, following waiver adoption, for-profit residential treatment facilities have greater odds of responding to a waiver by increasing provision of co-occurring mental health and SUD treatment compared with non-profit or public facilities (Ge, Romley, and Pacula 2024). Recent research documents that the 2014-2020 increase in for-profit ownership of IMDs was greater relative to non-IMDs, potentially due to the new opportunities for Medicaid payment through IMD exclusion waivers. In addition, the largest proportional change in Medicaid acceptance over that period occurred in for-profit IMDs. These findings suggest that variation in the impact of waivers may also be related to the delivery system context of the state in which they are implemented, particularly because evidence seems to indicate that waivers do not drive new facilities to open or other fundamental changes in supply. Rather, waiver implementation is associated with an increase in facilities accepting Medicaid payments, as demonstrated in Maclean (2021).

Opportunities and Challenges

A major opportunity arising from the implementation of SUD waivers is the possibility of transformational SUD treatment delivery model reforms. Findings to date suggest that only the

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

states with more comprehensive transformational reforms have been able to increase access to life-saving MOUDs. Increased access to a single treatment modality within the broader continuum of care may not be enough to substantialy improve SUD outcomes. One would hope that delivery model reforms would increase coordination of SUD treatment. Unfortunately, most studies of state waivers did not specifically explore coordination or continuity of care. More rigorous implementation studies are thus required to determine whether and how care continuity and coordination improve under particular waiver designs, and whether these changes produce improved outcomes.

Another opportunity arising from SUD IMD waivers is the ability to re-direct funds that states had previously used from highly-constrained block grants to offer residential services now covered under Medicaid. Moreover, the more expansive resources available through Medicaid waivers should expand access to a much broader group of Medicaid-eligible enrollees (E. Crable, Jones, et al. 2022; E.L. Crable, Benintendi, et al. 2022). Block grant funds can now be used to invest in increasing SUD supply—increasing the supply of treatment centers and/or training to increase the supply of SUD providers. Block grant funds could also be redirected towards SUD preventive programs, which are not usually covered under Medicaid.

While these opportunities are substantial, it is important to acknowledge that the results of most waiver studies are mixed. Proponents hoped that IMD SUD waivers will be used to spur system change. Yet, under CMS guidance encouraging more comprehensive reform, waiver take-up was short-lived and minimal across the states. It is impossible to know how many states would have submitted more comprehensive reforms if CMS guidance was not revised. Nonetheless, when CMS pivoted and encouraged a much more parsimonious streamlined reform, the vast majority of states submitted waiver designs that did just that. The streamlined guidance

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

allows states to implement less-comprehensive waivers that focus primarily on residential care, thus weakening their potential impact and perhaps even reducing the focus on access to community-based care – a primary concern with investments in residential care. Further research is needed to better understand these impacts, and whether the changed guidance was a significant driver of changes in waiver design. Although SUD waivers offer possibilities for transformational change, current CMS guidelines may not encourage that. In this way, waivers can present a challenge as they can encourage a singular focus on the change being waived – access to residential care – rendering other policy changes under the waiver more tenuous.

States must also determine whether the additional administrative burden of waivers (designing the waiver program, submitting to and negotiating with CMS, and implementation) is worth the accompanying gains. We write this, because it is clear that for many of the policies included under SUD waivers programs, the waiver was unnecessary. For example, state Medicaid programs could improve coverage for methadone treatment without waivers. And, as noted above, Maryland and other states had implemented many coverage expansions prior to the implementation of their waiver.

Another challenge is the time-limited nature of waivers. Changes made through the SUD waivers are tied to a timeline of implementation and subsequent renewal, instead of being tied more permanently to state Medicaid programs. This makes them more tenuous, particularly when proposed transformational changes could be lost with changes in waiver status.

Another major consideration relates to the significant variation in waiver policies and the need to understand which waiver policies matter. Although qualitative reviews of waivers have identified significant variation, quantitative analyses group waivers together and bluntly compare waiver to non-waiver states when evaluating access and outcomes (Maclean et al. 2021). Ideally,

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

future research will develop more complex measures of waiver programs—rather than simplistic dichotomous representations of states as either an SUD waiver or non-waiver state. We need to develop measures of comprehensive and restrictive waivers where particular policies can be pulled out, such as recovery coaches or intensive outpatient services, to determine if certain policies within waiver designs are more impactful.

It is equally essential to study the differential impacts of SUD waivers on care access and quality by facility ownership-type (public, private, non-profit). Secret shopper studies of non-Medicaid patients suggest that for-profit residential treatment centers use more aggressive and effective advertising and recruitment directed at patients and families, charging roughly more than twice as much as non-profits ($741 vs. $351 per day of residential treatment) in up-front costs for a 2-3 week stay in a facility for OUD treatment that may be more appropriately provided in non-residential settings (Beetham et al. 2020, 2021). Although these studies focused on non-Medicaid patients, it raises the question as to whether ownership status might influence SUD care given the shifting ecosystem of residential facilities available to Medicaid patients especially in SUD waiver states.

Conclusion

IMD waivers appear to have increased access to residential care, though it remains unclear whether such waivers improve the care process or expand access to MOUD treatment. Although states require residential facilities to offer MOUD and have pursued diverse policies to improve care coordination, the impacts of such waiver provisions remain unclear and under-studied. Although states seek to address long waiting lists and limited supply of care, waivers do not appear to promote the opening of new SUD treatment centers or to expand capacity within

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

existing centers. Notwithstanding these challenges, it is noteworthy that residential treatment for SUD is more widely available to Medicaid enrollees in states that implemented a waiver.

These mixed results raise the question of whether these waivers are an efficient and effective way to drive policy change at the state level. Waivers were originally intended for demonstration projects to assess the efficacy of new ideas advanced within specific states. Yet in this instance, waivers targeting the same challenges are being implemented across so many states at once that it is difficult to determine if the goal is to test new, innovative programming or to implement a policy change via waivers. In addition, the resources required for each state to individually design, implement, and evaluate a waiver might be better spent elsewhere—particularly if it has been determined that a significant policy change should be made. A strength of waivers is that the federal government can condition the opportunity on other changes (i.e., offering enhanced payment for residential care if transformational change is also implemented), but those changes are not being clearly evaluated to see what is effective and what is not, as most of the literature has thus far focused on the top-line change in residential care, without parsing out other relevant policy changes in individual states.

Given current proposals by Congressional Republicans to reduce federal Medicaid spending, which tend to focus on per-capita caps specific to particular Medicaid enrollee groups and on work requirements, SUD waivers might benefit from not being a target of reform. Perhaps because the overdose epidemic profoundly affected Republican constituencies and Republican-governed states, the first Trump administration reacted favorably to proposals to increase funding for SUD treatment. Streamlining waiver adoption and providing more opportunities for for-profit SUD treatment facilities may further fit the second Trump

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

administration's ideological predisposition. While a change in CMS guidance encouraging comprehensive reform would not be impossible, it seems unlikely in the near future.

■■■

Thomas Statchen is a second-year medical student at the Pritzker School of Medicine at the University of Chicago in Illinois. He earned a degree in bioengineering engineering with a double major in urban studies from the University of Pennsylvania. His research interests include health services research, health inequities, and the role of government in population health. thomas.statchen@uchicagomedicine.org

Harold Pollack is the Helen Ross Professor at the Crown Family School of Social Work, Policy, and Practice. He is also an Affiliate Professor in the Biological Sciences Collegiate Division and the Department of Public Health Sciences. Co-founder of the University of Chicago Crime Lab, he is co-director of the University of Chicago Health Lab. He is a committee member of the Center for Health Administration Studies (CHAS) at the University of Chicago. His current NIH-funded research concerns improved services for individuals at the boundaries of the behavioral health and criminal justice systems, disabilities, and two major new efforts to address the opioid epidemic in Illinois and across the nation.

Amanda J. Abraham, Michael and Caroline Fierman Professor in Public and International Affairs (PhD, Louisiana State University, 2006), specializes in addiction health services research and health policy. Her work focuses on the impact of federal and state policy on the accessibility and quality of substance use disorder treatment, the adoption, diffusion, and implementation of evidence-based practices for substance use disorder treatment, organizational change, and workforce development. Dr. Abraham's work has been published in top journals, including Health Affairs, JAMA Internal Medicine, JAMA Health Forum, American Journal of Public Health, Health Services Research, Psychiatric Services, Drug and Alcohol Dependence, and Journal of Studies on Alcohol and Drugs.

Christina M. Andrews' research focuses on public financing for substance use disorder treatment, with a particular focus on Medicaid. She is currently leading two national studies funded by the National Institutes of Health assessing the effects of Medicaid managed care on access to alcohol use disorder treatment and opioid use disorder treatment. Dr. Andrews also serves as Regional Editor for the Americas for Addiction, the leading international journal in the field. Her research has been supported by the Agency for Healthcare Quality and Research, the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, other government and nonprofit organizations.

Colleen M. Grogan, PhD is the Deborah R. and Edgar D. Jannotta Professor in the University of Chicago Crown Family School of Social Work, Policy, and Practice. She is also the Deputy Dean for Curriculum for the Crown Family School. She is Associate Editor of Health Policy for the American Journal of Public Health and was the Editor of the Journal of Health Politics, Policy & Law from 2010-2016. Grogan is the Academic Director of the interdisciplinary Graduate Program on Health Administration & Policy (GPHAP) at the University of Chicago.

Forthcoming in *Journal of Health Politics, Policy and Law*. DOI: 10.1215/03616878-12166733.

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

References

Albertson, Elaine Michelle, Christopher Scannell, Neda Ashtari, and Elizabeth Barnert. 2020. "Eliminating gaps in Medicaid coverage during reentry after incarceration." *American Journal of Public Health* 110, no. 3: 317-321.https://doi.org/10.2105/AJPH.2019.305400. https://www.ncbi.nlm.nih.gov/pubmed/31944846.

Allen, Lindsay, Medicaid Outcomes Distributed Research Network, Evan Cole, Michael Sharbaugh, Anna Austin, Marguerite Burns, Chung-Chou Ho Chang et al. 2023. "Use of residential opioid use disorder treatment among Medicaid enrollees in nine states." *Journal of substance use and addiction treatment* 149: 209034. https://pubmed.ncbi.nlm.nih.gov/37059269/

Andrews, Christina M., Harold A. Pollack, Amanda J. Abraham, Colleen M. Grogan, Clifford S. Bersamira, Thomas D'aunno, and Peter D. Friedmann. 2019. "Medicaid coverage in substance use disorder treatment after the affordable care act." *Journal of substance abuse treatment* 102: 1-7. https://doi.org/10.1016/j.jsat.2019.04.002. https://pmc.ncbi.nlm.nih.gov/articles/PMC6578872/

Bass, Brittany, Darren Urada, Dhruv Khurana, Anne Boustead, and Vandana Joshi. 2023. "The effect of the drug Medi-Cal organized delivery system 1115 demonstration waiver on substance use disorder treatment access: evidence from California." *Drug and Alcohol Dependence* 246: 109847.https://doi.org/10.1016/j.drugalcdep.2023.109847. https://www.ncbi.nlm.nih.gov/pubmed/37001321.

Beetham, Tamara, Brendan Saloner, Marema Gaye, Sarah E. Wakeman, Richard G. Frank, and Michael L. Barnett. 2020. "Therapies offered at residential addiction treatment programs in the United States." *Jama* 324, no. 8: 804-806. https://doi.org/10.1001/jama.2020.8969. https://www.ncbi.nlm.nih.gov/pubmed/32840587.

Beetham, Tamara, Brendan Saloner, Marema Gaye, Sarah E. Wakeman, Richard G. Frank, and Michael Lawrence Barnett. 2021. "Admission Practices And Cost Of Care For Opioid Use Disorder At Residential Addiction Treatment Programs In The US: Study examines practices and cost of care for opioid use disorder at residential additional programs." *Health Affairs* 40, no. 2: 317-325.https://doi.org/10.1377/hlthaff.2020.00378. https://www.ncbi.nlm.nih.gov/pubmed/33523744.

Chua, Kao-Ping, Mark C. Bicket, Amy SB Bohnert, Rena M. Conti, Pooja Lagisetty, and Thuy D. Nguyen. 2024. "Buprenorphine dispensing after elimination of the waiver requirement." *New England Journal of Medicine* 390, no. 16: 1530-1532. https://doi.org/10.1056/NEJMc2312906. https://www.ncbi.nlm.nih.gov/pubmed/38657250.

Cioe, Katharine, Breanne E. Biondi, Rebecca Easly, Amanda Simard, Xiao Zheng, and Sandra A. Springer. 2020. "A systematic review of patients' and providers' perspectives of medications for treatment of opioid use disorder." *Journal of substance abuse treatment* 119: 108146. https://doi.org/10.1016/j.jsat.2020.108146. https://www.ncbi.nlm.nih.gov/pubmed/33138929.

CMS (Center for Medicare and Medicaid Services). 2015. *SMD # 15-003: New Service Delivery Opportunities for Individuals with a Substance Use Disorder.* July. https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf.

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

CMS (Center for Medicare and Medicaid Services). 2017. *SMD # 17-003: RE: Strategies to Address the Opioid Epidemic.* November. https://www.medicaid.gov/federal-policy-guidance/downloads/SMD17003.pdf.

Cohen, Cathren, Héctor Hernández-Delgado, and Alexis Robles-Fradet. 2021. "Medicaid section 1115 waivers for substance use disorders: a review." *Washington, DC: National Health Law Program*: 42. https://healthlaw.org/wp-content/uploads/2021/06/FINAL_Medicaid-1115-Waivers-for-SUD-updated.pdf.

Crable, Erika, David K. Jones, Alexander Y. Walley, Jacqueline Milton Hicks, Allyn Benintendi, and Mari-Lynn Drainoni. 2022. "How Do Medicaid Agencies Improve Substance Use Treatment Benefits? Lessons from Three States' 1115 Waiver Experiences." *Journal of health politics, policy and law* 47, no. 4: 497-518. https://doi.org/10.1215/03616878-9716740. https://www.ncbi.nlm.nih.gov/pubmed/35044466.

Crable, Erika L., Allyn Benintendi, David K. Jones, Alexander Y. Walley, Jacqueline Milton Hicks, and Mari-Lynn Drainoni. 2022. "Translating Medicaid policy into practice: policy implementation strategies from three US states' experiences enhancing substance use disorder treatment." *Implementation Science* 17, no. 1: 3. https://doi.org/10.1186/s13012-021-01182-4. https://www.ncbi.nlm.nih.gov/pubmed/34991638.

CRS (Congressional Research Service). 2023. *Medicaid's Institution for Mental Diseases (IMD) Exclusion.* February. https://crsreports.congress.gov/product/pdf/IF/IF10222.

Cunningham, Peter, Cynthia Woodcock, Matthew Clark, Alice Middleton, Andrew Barnes, David Idala, Xue Zhao, and Julie Donohue. 2020. *Expanding access to addiction treatment services through section 1115 waivers for substance use disorders: Experiences from Virginia and Maryland*. Academy Health.

de Andrade, Dominique, Rachel A. Elphinston, Catherine Quinn, Julaine Allan, and Leanne Hides. "The effectiveness of residential treatment services for individuals with substance use disorders: A systematic review." *Drug and alcohol dependence* 201 (2019): 227-235. https://pubmed.ncbi.nlm.nih.gov/31254749/

Dixon, Lisa B., and Howard H. Goldman. 2019. "Introduction to "Medicaid's Institutions for Mental Diseases (IMD) Exclusion Rule: A Policy Debate"." *Psychiatric Services* 70, no. 1: 2-3. https://doi.org/10.1176/appi.ps.201800412. https://www.ncbi.nlm.nih.gov/pubmed/30501468.

Frank, Richard G., Keith N. Humphreys, and Harold A. Pollack. 2021. "Policy responses to the addiction crisis." *Journal of Health Politics, Policy and Law* 46, no. 4: 585-597. https://doi.org/10.1215/03616878-8970796. https://www.ncbi.nlm.nih.gov/pubmed/33493325.

Gastala, Nicole, Harold A Pollack, Basmattee Boodram, Mai Tuyet Pho, and Mary Beth Shapley. 2024. "Expanding access to addiction treatment." *Brookings Institute*. https://www.brookings.edu/articles/expanding-access-to-addiction-treatment/

Ge, Yimin, John A. Romley, and Rosalie Liccardo Pacula. 2024. "The Impact of Medicaid Institutions for Mental Disease Exclusion Waivers on the Availability of Substance Abuse Treatment Services and the Varying Effect by Ownership Type." *The Milbank Quarterly* 102, no. 3: 669-691. https://doi.org/10.1111/1468-0009.12710. https://www.ncbi.nlm.nih.gov/pubmed/38966909.

Jones, Christopher M., Beth Han, Grant T. Baldwin, Emily B. Einstein, and Wilson M. Compton. 2023. "Use of medication for opioid use disorder among adults with past-year opioid use disorder in the US, 2021." *JAMA Network Open* 6, no. 8: e2327488-e2327488.

Downloaded from http://read.dukeupress.edu/jhppl/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

UNEDITED MANUSCRIPT

https://doi.org/10.1001/jamanetworkopen.2023.27488.
https://www.ncbi.nlm.nih.gov/pubmed/37548979.

Jones, Christopher M., Yngvild Olsen, Mir M. Ali, Tisamarie B. Sherry, Jana Mcaninch, Timothy Creedon, Patti Juliana et al. 2023. "Characteristics and prescribing patterns of clinicians waivered to prescribe buprenorphine for opioid use disorder before and after release of new practice guidelines." In *JAMA Health Forum*, vol. 4, no. 7, pp. e231982-e231982. American Medical Association. https://doi.org/10.1001/jamahealthforum.2023.1982. https://www.ncbi.nlm.nih.gov/pubmed/37477926.

Kennedy-Hendricks, Alene, Minna Song, Alexander D. McCourt, Joshua M. Sharfstein, Matthew D. Eisenberg, and Brendan Saloner. 2023. "Licensure Policies May Help States Ensure Access To Opioid Use Disorder Medication In Specialty Addiction Treatment: Study examines state licensure policies and access to opioid use disorder medication in specialty addition treatment." *Health Affairs* 43, no. 5: 732-739. https://doi.org/10.1377/hlthaff.2023.01306. https://www.ncbi.nlm.nih.gov/pubmed/38709972.

KFF (Kaiser Family Foundation). 2025. *Medicaid waiver tracker: Approved and pending section 1115 waivers by State.* April. https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/.

Koehl, Jennifer L., David E. Zimmerman, and Patrick J. Bridgeman. 2019. "Medications for management of opioid use disorder." *American Journal of Health-System Pharmacy* 76, no. 15: 1097-1103. https://doi.org/https://doi.org/10.1093/ajhp/zxz105

LeFevre, Nicholas, Joshua St Louis, Emma Worringer, Morgan Younkin, Natalie Stahl, and Mia Sorcinelli. 2023. "The end of the X-Waiver: excitement, apprehension, and opportunity." *The Journal of the American Board of Family Medicine* 36, no. 5: 867-872. https://doi.org/10.3122/jabfm.2023.230048R1. https://www.ncbi.nlm.nih.gov/pubmed/37704389.

Lindner, Stephan, Kyle Hart, Brynna Manibusan, Kirbee A. Johnston, Dennis McCarty, and K. John McConnell. 2024. "Effects Of Medicaid Waivers On Use Of Medications For Opioid Use Disorder And Nonfatal Overdoses In 17 States: Article examines Medicaid waivers, the utilization of opioid use disorder medications, and nonfatal overdoses." *Health Affairs*43, no. 11: 1597-1604. https://doi.org/10.1377/hlthaff.2024.00461. https://www.ncbi.nlm.nih.gov/pubmed/39496087.

Maclean, Johanna Catherine, Hefei Wen, Kosali I. Simon, and Brendan Saloner. 2021. "Institutions for mental diseases Medicaid waivers: impact on payments for substance use treatment facilities: study examines Medicaid coverage of substance use disorder treatment at residential and outpatient facilities." *Health Affairs* 40, no. 2: 326-333. https://doi.org/10.1377/hlthaff.2020.00404. https://www.ncbi.nlm.nih.gov/pubmed/33523735.

NCHS (National Center for Health Statistics). 2025. National Vital Statistics System, Provisional drug overdose death counts. https://dx.doi.org/10.15620/cdc/20250305008

Onah, Michael E. 2021. "The Patient-to-Prisoner Pipeline: The IMD exclusion's adverse impact on mass Incarceration in United States." *American Journal of Law & Medicine* 44, no. 1: 119-144. https://doi.org/10.1177/0098858818763818. https://www.ncbi.nlm.nih.gov/pubmed/29764321.

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

Paiva, Taylor J., Rachel S. Wightman, Kristen St John, Adam Z. Nitenson, Collette Onyejekwe, and Benjamin D. Hallowell. 2024. "Buprenorphine prescribing and treatment accessibility in response to regulation changes due to the COVID-19 public health emergency." *Journal of Substance Use and Addiction Treatment* 162: 209382. https://doi.org/10.1016/j.josat.2024.209382. https://www.ncbi.nlm.nih.gov/pubmed/38677597.

Roy, Payel Jhoom, Katie Suda, Jing Luo, MyoungKeun Lee, Joel Anderton, Donna Olejniczak, and Jane M. Liebschutz. 2024. "Buprenorphine dispensing before and after the April 2021 X-Waiver exemptions: an interrupted time series analysis." *International Journal of Drug Policy* 126: 104381. https://doi.org/10.1016/j.drugpo.2024.104381. https://www.ncbi.nlm.nih.gov/pubmed/38457960.

Saunders, Heather, and Kathy Gifford. 2024. *State Approaches to Addressing the Opioid Epidemic: Findings from a Survey of State Medicaid Programs.* Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/state-approaches-to-addressing-the-opioid-epidemic-findings-from-a-survey-of-state-medicaid-programs/.

Slocum, Susannah, Catherine E. Paquette, and Robin A. Pollini. 2023 "Drug treatment perspectives and experiences among family and friends of people who use illicit opioids: A mixed methods study." *Journal of Substance Use and Addiction Treatment* 148: 209023. https://doi.org/10.1016/j.josat.2023.209023. https://www.ncbi.nlm.nih.gov/pubmed/36940779.

Sugarman, Olivia K., Wenshu Li, and Brendan Saloner. 2024. "Medications for opioid use disorder increased among Louisiana Medicaid enrollees during policy reforms, 2018–21." *Health Affairs* 43, no. 1: 46-54. https://doi.org/10.1377/hlthaff.2023.00715. https://www.ncbi.nlm.nih.gov/pubmed/38190602.

Wakeman, Sarah E., Marc R. Larochelle, Omid Ameli, Christine E. Chaisson, Jeffrey Thomas McPheeters, William H. Crown, Francisca Azocar, and Darshak M. Sanghavi. 2020. "Comparative effectiveness of different treatment pathways for opioid use disorder." *JAMA network open* 3, no. 2: e1920622-e1920622. https://pubmed.ncbi.nlm.nih.gov/32022884/

Table 1 States with newly approved IMD exclusion waivers per year, 1993–2024

Year	Total approved	States
1993-2009	9	Arizona, Delaware, Maryland, Massachusetts, New York, Rhode Island, Oregon, Vermont, Tennessee
2009-2016	1	Massachusetts
2016	3	California, Virginia
2017	6	New Jersey, Utah, Maryland
2018	17	Alaska, Indiana, Illinois, Kentucky, Louisiana, New Hampshire, New Mexico, Pennsylvania, Vermont, Washington, West Virginia

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025

2019	24	Delaware, Michigan, Minnesota, North Carolina, Nebraska, Ohio, Wisconsin
2020	29	DC, Idaho, Kansas, Oklahoma, Rhode Island
2021	32	Colorado, Maine, Oregon
2022	34	Connecticut, Montana
2023	36	Nevada, Missouri
2024	37	New York
Pending		Alabama, Arizona, Arkansas

UNEDITED MANUSCRIPT

Downloaded from http://read.dukeupress.edu/jhpp/article-pdf/doi/10.1215/03616878-12166733/2299110/12166733.pdf by guest on 23 September 2025