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March 5, 2026

The Honorable Robert F. Kennedy, Jr., Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

**RE: Florida Institutions for Mental Disease
Section 1115 Demonstration**

Dear Secretary Kennedy:

The National Health Law Program (NHeLP) appreciates the opportunity to comment on Florida's proposed "Institutions for Mental Disease Section 1115 Demonstration."¹ For over 55 years, NHeLP has advocated, educated, and litigated to preserve, protect, and expand access to health care for low-income and underserved populations.

NHeLP recommends that the Centers for Medicare and Medicaid Services (CMS) reject Florida's request to obtain federal financial participation (FFP) for expenditures for Medicaid services in institutions for mental disease (IMDs).

Florida's request falls far outside of CMS's own articulated parameters for substance use and mental health demonstrations and fails to comply with the requirements of section 1115.

I. HHS Authority Under Section 1115.

For the Secretary to approve a project pursuant to section 1115, the project must:

- propose an “experimental, pilot, or demonstration;”
- 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.

Discussing each of these limitations a bit further:

First, the state must propose to conduct an “experimental, pilot, or demonstration” project. This demands a “novel approach” to program administration.² To evaluate whether a proposed project is a valid experiment, the Secretary needs to know what will be tested and how, at the point in time when the project is being approved.

Second, the project must promote the Medicaid Act’s objectives. According to Congress, the purpose of Medicaid is to enable states “to furnish[] medical assistance” to individuals “whose income and resources are insufficient to meet the costs of necessary medical services” and to provide “rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.”³ Thus, the “central objective” of the Medicaid Act is “to provide medical assistance,” that is to provide health coverage.⁴

¹ Fla. Agency for Health Care Admin., *Institutions for Mental Disease Coverage for Individuals Diagnosed with Mental Illness and/or Substance Use Disorder Section 1115 Title XIX Research Demonstration* (Jan. 16, 2026), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/fl-inst-mntl-disase-pndng-aplctn-01162026.pdf> [hereinafter *Florida 1115 IMD Application*].

² *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994).

³ 42 U.S.C. § 1396-1; *id.* § 1396d(a) (defining “medical assistance” as provision of, or payment for, specified health care and services).

⁴ *Stewart v. Azar*, 366 F. Supp. 3d 125, 138 (D.D.C. 2019); *id.* at 144 (rejecting “promoting health” as an independent objective because the Medicaid Act is “designed ... to address not health generally but the provision of care to needy populations” through a health insurance program).

Third, the Secretary can only waive provisions set forth in section 1396a of the Medicaid Act. The Secretary cannot waive requirements contained in sections 1396b through 1396w-6.⁵ 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.⁶ 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 merely provides the authorization necessary for federal reimbursement of expenditures for a project that has been approved under section 1115(a)(1). To be clear, as worded, section 1115 does not include an independent, freestanding expenditure authority.⁷ The text of the statutes must control—and limit—the actions of the federal agency, in this case limiting HHS to using federal Medicaid funding only for experimental projects that are consistent with Medicaid’s objectives and that waive only provisions set forth in section 1396a.⁸

Fourth, section 1115 allows approvals only “to the extent and for the period . . . necessary” to carry out the experiment.⁹ The Secretary cannot use section 1115 to permit states to make long-term policy changes.

As detailed below, Florida’s request for FFP for services provided in IMDs exceeds the limitations of section 1115 by failing to propose a legitimate experiment and by requesting waiver of a provision the Secretary does not have authority to waive.

⁵ See 42 U.S.C. § 1315(a)(1).

⁶ *Id.* § 1315(a)(2).

⁷ See, e.g., *Portland Adventist Med. Ctr. v. Thompson*, 399 F.3d 1091, 1097 (9th Cir. 2005) (“Section 1115 does not establish a new, independent funding source. It authorizes the Secretary to ‘waive compliance with any of the requirements of’ a series of provisions of the Social Security Act in approving demonstration projects.”).

⁸ See *West Virginia v. EPA*, 597 U.S. 697 (2022).

⁹ 42 U.S.C. § 1315(a); see also *id.* §§ 1315(e)(2), (f)(6) (limiting the extension of “state-wide, comprehensive demonstration projects” to one initial extension of up to 3 years (5 years, for a waiver involving Medicare-Medicaid eligible individuals) and one subsequent extension not to exceed to 3 years (5 years, for Medicare-Medicaid waivers)).

II. Florida's Request for FFP for Services Provided in IMDs.

Florida requests FFP for services provided to individuals residing in IMDs for up to 90 days.¹⁰ Specifically, Florida seeks to obtain FFP for services up to 90 days in three institutional settings: psychiatric residential care facilities for adults (ages 21-64 years old) diagnosed with a serious mental illness (SMI); addiction receiving facility services for children and adults diagnosed with a moderate to severe substance use disorder (SUD); and short-term residential treatment facility services for children and adults following crisis stabilization.¹¹

We generally object to Florida's request for FFP for services in IMDs for the same reasons we have objected to numerous previous demonstrations that waived the IMD exclusion.¹² Namely, providing FFP for services in IMDs is not a legitimate experiment;

¹⁰ *Florida 1115 IMD Application* at 10.

¹¹ *Id.* The request does not provide enough information to determine the extent to which Florida is requesting FFP for services in IMDs for children, and the application does not clearly define the types of facilities it seeks to cover, beyond the broad description cited above. *See infra* Part II(D).

¹² *See, e.g.,* Comments on Arkansas Opportunities to Test Transition-Related Strategies to Support Community Reentry from Incarceration and Institutions for Mental Disease Section 1115 Demonstration Project (Mar. 29, 2024); <https://healthlaw.org/wp-content/uploads/2024/04/NHeLP-Comments-on-Reentry-and-IMD-Demonstration.pdf>; Comments on California BH-Connect 1115 Waiver Submission (Nov. 27, 2023), <https://healthlaw.org/resource/nhelp-federal-comments-on-california-bh-connect-1115-waiver-submission/>; Comments on New York State Medicaid Section 1115 Demonstration Medicaid Redesign Team (MRT) Waiver Amendment Request (Feb. 3, 2023), <https://healthlaw.org/resource/nhelp-comments-on-new-york-state-medicaid-section-1115-demonstration-amendment/>; Comments on New Hampshire SUD/SMI/SED Treatment and Recovery Access Demonstration Extension Request (Nov. 16, 2022), <https://healthlaw.org/resource/nhelp-comments-on-new-hampshire-sud-smi-sed-treatment-and-recovery-access-demonstration-extension-request/>; Comments on Missouri Section 1115 Request for Federal Funding for Institutions for Mental Disease (IMDs) for Children and Adults (Sept. 30, 2022), <https://healthlaw.org/resource/comments-on-missouri-section-1115-request-for-federal-funding-for-institutions-for-mental-disease-imds-for-children-and-adults/>; Comments: Washington Medicaid Transformation Project Demonstration Extension Request (Aug. 31, 2022), <https://healthlaw.org/resource/washington-medicaid-transformation-project-demonstration-extension-request/>; Comments: NHeLP Comments on West Virginia Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders (SUD) Demonstration Extension Request (July 10, 2022), <https://healthlaw.org/resource/nhelp-comments-on-west-virginia-creating-a-continuum-of-care-for-medicaid-enrollees-with-substance-use-disorders-sud-demonstration-extension-request/>; Comments on Louisiana's Section 1115

the Secretary does not have authority to waive provisions outside of 42 U.S.C. § 1396a; and providing FFP for services in institutions risks diverting resources from community-based services. We object specifically to Florida’s request to extend the length of stay permitted by SMI/SED demonstrations to up to 90 days, as such a request risks increasing institutionalization, and makes it difficult for individuals to access community living. Furthermore, such a request falls outside the parameters of CMS’ policy and practice of limiting both SUD and SMI IMD waivers to 30 days average length of stay, and 60 days as an absolute maximum for SMI IMD waivers.¹³ Rather than seeking federal funding for more beds—which is an express goal of this demonstration request—Florida should strengthen its behavioral health services by boosting proven home and community-based care for children and adults.¹⁴

A. Florida Has Not Proposed a Legitimate Experiment.

Section 1115 allows HHS to waive some requirements of the federal Medicaid Act so that states can test novel approaches to improving medical assistance for low-income individuals, if such waivers are limited to the extent and time period needed to carry out the experiment or demonstration. This means that a section 1115 demonstration waiver

Waiver Renewal Application (June 24, 2022), https://1115publiccomments.medicaid.gov/jfe/file/F_1Ov6i4itJALWZY9; Comments on New Hampshire Section 1115 Demonstration, Amendment #2 Request (Oct. 20, 2022), https://1115publiccomments.medicaid.gov/jfe/file/F_2c7ot76ZZe5t2MY; Comments on Pennsylvania Medicaid Coverage for Former Foster Youth From a Different State and SUD Demonstration Extension Request (May 12, 2022), https://1115publiccomments.medicaid.gov/ControlPanel/File.php?F=F_2aLVZVDxZo8N518; Comments on California Section 1115 Demonstration Five-Year Renewal and Amendment Request: CalAIM Demonstration (Aug. 12, 2021), <https://healthlaw.org/resource/nhelp-comments-on-california-section-1115-demonstration-five-year-renewal-and-amendment-request-calaim-demonstration/>; Comments on Alabama’s Section 1115 Institutions for Mental Disease Waiver for Serious Mental Illness (Apr. 24, 2021), https://gov1.qualtrics.com/ControlPanel/File.php?F=F_r2oyBsIWQfN45IT.

¹³ CMS, Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Demonstration Opportunity Technical Assistance Questions and Answers (Nov. 4, 2019), <https://www.medicaid.gov/media/40711>; CMS, State Medicaid Director Letter Strategies to Address Opioid Epidemic, SMD #17-003, (Nov. 1, 2017), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>; CMS, State Medicaid Director Letter, Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance, SMD # 18-011 (Nov. 13, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>.

¹⁴ *Florida 1115 IMD Application* at 7-8.

request must propose a genuine experiment of some kind. It is not sufficient that the state seeks to simply save money through a section 1115 demonstration waiver; the state must seek to test out new ideas and ways of addressing problems faced by enrollees.¹⁵

FFP for services in IMDs is not an experiment, and it certainly is not a new idea or approach to addressing the needs of enrollees. As we have noted in our previous comments on such waivers, for almost 30 years, CMS has granted states the authority to waive the IMD exclusion, despite the illegality of such waivers. The first waiver was granted in 1993, and as of 2009, CMS phased out all but one of these IMD waiver projects, precisely because they were no longer “innovative or experimental.”¹⁶

Although CMS has reversed course and encouraged states to apply for section 1115 waivers that would allow for FFP for time-limited services provided in IMDs, CMS has not provided any justification for its change in position, nor has Florida provided any evidence here as to why its requests are “experimental.”¹⁷ With over 30 years of experience with “IMD waivers,” it is no longer plausible to claim that providing FFP for services to individuals residing in IMDs is a bona fide experiment or demonstration. Section 1115 does not offer HHS a permanent “back door” to provide funding for settings that Congress explicitly carved out of Medicaid.

B. The Secretary Does Not Have Authority to Waive Compliance with Provisions Outside of Section 1396a.

Because the IMD exclusion lies outside of section 1396a, it cannot be waived.¹⁸ The IMD exclusion is contained in section 1396d, which specifically excludes from the definition of medical assistance “any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases”¹⁹ Moreover, as noted above, section 1115(a)(2)

¹⁵ *Beno*, 30 F.3d at 1069.

¹⁶ U.S. Gov. Accounting Office, *States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies* 29 (2017), <https://www.gao.gov/assets/690/686456.pdf>.

¹⁷ See CMS, Dear State Medicaid Director Letter, SMD #18-011, Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance (Nov. 13, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>.

¹⁸ 42 U.S.C. § 1315(a)(1).

¹⁹ 42 U.S.C. § 1396d(a)(31)(B).

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.

C. Florida’s Request Fails to Strengthen Community-Based Services and Risks Increased Rates of Institutionalization.

Repeated investments in institutional settings with the goal of creating additional capacity risks increasing the unjustified segregation of people with disabilities, particularly when community-based services in Florida are underfunded and not reliably available for those who need them.

1. Florida Lacks Effective Community-Based Mental Health Services.

Florida does not have sufficient community-based mental health services to meet the needs of its residents.²⁰ Florida has 219 federally designated mental health shortage areas with its workforce levels only meeting 24% of the state’s total estimated need.²¹ One study, which Florida cited in its application to support its waiver request, noted that the state “has one of the lowest behavioral health provider supply ratios” and that Floridians “only received 22.7% of the number of therapy visits” compared to those living in areas with the highest provider supply.²² Florida also ranks 42nd nationally in the number of psychiatrists available per resident.²³ Florida’s own assessment acknowledges a workforce shortage of more than 25,000 behavioral health professionals, including twenty counties with no resident psychiatrist.²⁴

²⁰ Florida ranks 34th in Mental Health America’s Access to Care State Rankings. See Maddy Reinhert et al., Mental Health America, *The State of Mental Health in America: 2025* (Oct. 2025), <https://mhanational.org/wp-content/uploads/2025/09/State-of-Mental-Health-2025.pdf>.

²¹ Univ. of S. Fla., Coll. Of Behavioral and Cmty. Scis., *Statewide center at USF launches Florida’s first-of-its-kind interactive dashboard addressing behavioral health workforce shortage* (Oct. 13, 2025), <https://www.usf.edu/cbcs/news/2025/florida-launches-interactive-dashboard-to-address-behavioral-health-workforce-shortage.aspx>.

²² Stoddard Davenport et al., Milliman Report, *Access across America: State-by-state insights into the accessibility of care for mental health and substance use disorders 2* (Dec. 2023), https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2023-Articles/12-12-23_Milliman-Report-Access-across-America.pdf.

²³ Marcus Roberstson, *All 50 states ranked by psychiatrist per capita*, Becker’s Behavioral Health (Apr. 28, 2025), <https://www.beckersbehavioralhealth.com/behavioral-health-news/all-50-states-ranked-by-psychiatrists-per-capita/>.

²⁴ Fla. Comm’n on Mental Health and Substance Use Disorder, *Behavioral Gap Health Analysis 9* (2025), <https://flmhac.org/bh-gap-analysis-report>.

Additionally, Florida’s investment in mobile response and home and community-based crisis stabilization fails to meet the state’s need. While Florida’s application notes that the state has “more than 50” mobile crisis response teams, these teams are scattered across a state with a population of over 21.5 million people.²⁵ There are many counties that these mobile crisis teams do not serve. Florida gives no information about how quickly these units can respond to children and adults in crisis, if and how they work to stabilize people at home to avoid institutionalization, or how these services work in tandem with other community-based services to connect people to longer-term supports and services to avoid cycling. The Florida Commission on Mental Health and Substance Use Disorder’s most recent report recognizes that Florida does not have enough Assertive Community Treatment teams, especially in rural areas, which is a key driver of prolonged inpatient and crisis stabilization stays.²⁶

The Florida Commission on Mental Health and Substance Use Disorder set forth numerous steps that Florida could take to improve its community-based services, including “develop[ing] new care coordination teams that use the Critical Time Intervention (CTI) model for individuals” with a high service need, and “[i]ncrease[ing] the number of Florida Assertive Community Treatment teams and Forensic Multidisciplinary Teams statewide.”²⁷ In addition, the report suggests that inadequate upstream services is driving the “need” for extended residential placement.²⁸ The report notes that insufficient step-down options delay discharge, and that the state lacks resources to sustain independent living once individuals are discharged.²⁹

While Floridians’ need for mental health care and SUD services clearly outstrips supply, the issue cannot be simplified as a “bed shortage” issue, as the need for beds depends

²⁵ Fla. Dept. of Children and Families, *Special Treatment Team Services*, <https://www.myflfamilies.com/specialty-treatment-team-maps> (last visited March 4, 2026).

²⁶ See Fla. Comm’n on Mental Health and Substance Use Disorder, *Annual Interim Report 31-32* (2025), <https://www.myflfamilies.com/sites/default/files/2025-05/2024%20Annual%20Commission%20on%20Mental%20Health%20and%20Substance%20Abuse%20Disorder%20Interim%20Report.pdf> (“[I]ndividuals are unable to step down from more intense levels of short– term residential service (e.g., level 1 or 2) to less intense levels of residential support (e.g., level 3 or 4) because of the unavailability of residential options. This gap has created an increased demand for acute behavioral health services, preventing new patients from accessing the care they need.”)

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*

on a number of interrelated factors and may not be uniform across a state. Experts agree that the robustness of other parts of the continuum of care directly impacts the need for beds, and thus what appears to be a shortage of beds may in fact be a lack of adequate community-based services.³⁰

2. Florida Lacks Sufficient Community-Based Substance Use Disorder Services.

Despite the importance of community-based services for individuals with SUD, Florida is currently experiencing a shortage of providers for many of these services, which would likely drive patients to inpatient facilities instead. For example, Florida currently has one of the lowest buprenorphine dispensing rates, despite the proven effectiveness of the medication and recent federal efforts to make it easier for primary care providers to prescribe the medication.³¹ The State also has a lower number of opioid treatment programs (OTPs), which provide access to methadone and other forms of medication-assisted treatment (MAT) in the communities, than similarly situated states. Most programs are located in urban areas, resulting in a significant lack of access to community-based SUD care in rural parts of Florida.³²

3. Florida's Request Does Not Include Adequate Strategies to Address Needs.

CMS has been explicit that authorization for FFP for services to residents of IMDs is contingent upon assurance from the state that "community-based alternatives are or will be available throughout the state under the state's financing plan described above, and CMS has approved the SMI/SED demonstration's implementation plan."³³ Nothing

³⁰ American Psychiatric Ass'n, *The Psychiatric Bed Crisis in the U.S.: Understanding the Problem and Moving Toward Solutions* (May 2022) (proposing a bed-needs model that factors in the availability of community-based resources).

³¹ See CDC, Buprenorphine Dispensing Rate Maps (2026), <https://www.cdc.gov/overdose-prevention/data-research/facts-stats/buprenorphine-dispensing-maps.html>.

³² See SAMHSA, Opioid Treatment Program Directory, https://www.samhsa.gov/find-help/locators/opioid-treatment-program-directory?state=All&order=value_3&sort=asc&page=2 (last visited Feb. 27, 2026).

³³ See CMS, Dear State Medicaid Director Letter, SMD #18-011, Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance at 7 (Nov. 13, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>

in the waiver indicates that Florida is pursuing solutions to appropriately fill the gaps in its continuum of care described above. Instead, Florida seeks to create and fill more beds, without a clear plan to provide rehabilitative care or warm hand-offs to community-based services. To the extent that Florida does intend to fill identified gaps, they have not provided sufficient information about how they intend to achieve that goal to allow for meaningful public input.³⁴

Florida has long relied on its involuntary civil commitment statute, known as the Baker Act, to address the mental health needs of its residents. Over 100,000 Floridians were subjected to involuntary examinations for civil commitment in Fiscal Year 2024-2025.³⁵ The effects of these involuntary commitments can be devastating, especially for children.³⁶ The proposed demonstration doubles down on this approach, requesting increased federal investment in inpatient stays while failing to articulate a strategy to invest in community-based services.

The same is true for people with SUD seeking recovery services. Regardless of whether individuals with SUD begin their treatment in residential or community-based settings, people need access to a full array of community-based treatment options tailored to their individual needs, which will change as they progress in their recovery.³⁷ For

³⁴ Although CMS permits states to submit their implementation plans either as part of the application or as part of the post approval demonstrations, the state should at least provide an indication of intention to fill these gaps, as a request for a demonstration request must comply with the public notice process set forth in 431.408(a), which requires as part of the state level notice, "a comprehensive description of the demonstration application or extension to be submitted to CMS that contains a sufficient level of detail to ensure meaningful input from the public." 42 C.F.R. §§ 431.412; 431.408(a).

³⁵ Univ. of S. Fla., *The Baker Act Annual Report Fiscal Year 2024-2025* 3 (2025), https://www.usf.edu/cbcs/baker-act/documents/ba_usf_annual_report_2024_2025.pdf

³⁶ As noted above, *supra* note 11, the application does not contain enough information to determine whether Florida is requesting FFP for mental health services in settings designated for children under age 21. Research has shown that subjecting children to involuntary psychiatric hospitalization can lead to a host of negative outcomes, including exacerbating mental health conditions, missed educational opportunities, and erosion of trust in medical professionals. S. Poverty L. Center, *Costly and Cruel How Abuse of the Baker Act Harms 37,000 Florida Children Each Year* 17 (2021), https://www.splcenter.org/wp-content/uploads/files/com_special_report_baker_act_costly_and_cruel.pdf.

³⁷ Hannah Katch & Judith Solomon, Ctr. on Budget & Policy Priorities, *Repealing Medicaid Exclusion for Institutional Care Risks Worsening Services for People With Substance Use Disorders* (April 24, 2018), <https://www.cbpp.org/research/health/repealing-medicaid-exclusion-for-institutional-care-risks-worsening-services-for>.

example, they often need ongoing community-based services such as case management, MAT, and peer support services to maintain their recovery, prevent relapse, and quickly return to treatment if relapses occur.³⁸ Expanding incentives to utilize residential treatment by permitting FFP for services provided in IMDs could undermine efforts to ensure the appropriate continuum of care. For example, if states receive more funds for IMDs, but this is not balanced out by additional funding incentives for chronically underfunded community-based services, it “may simply encourage greater use of expensive inpatient treatment, including for people for whom it may not be the best option.”³⁹ Furthermore, increasing funding to inpatient facilities could increase dangers to patients with opioid use disorder if such facilities primarily focus on detoxification. As experts have noted, increased funding for facilities can cause a particular risk if people “who receive inpatient care aren’t then connected to community-based treatment programs or put on a medication, leaving them extremely vulnerable to relapse and overdose.”⁴⁰

While CMS generally requires states to abide by a “maintenance of effort” (MOE) provision as a condition of receiving approval of this kind of demonstration, such mechanisms are inadequate when the underlying community-based system is inadequate. An MOE cannot correct for chronic under-funding and shortages of community-based services.

Instead, a proven method to expand access to mental health care and substance use disorder services would be to adopt full Medicaid expansion. Research demonstrates that states that have expanded Medicaid have shown “improvements in access to medications and services for the treatment of behavioral health (mental health and [SUD]) conditions” compared to non-expansion states.⁴¹ Annual outpatient treatment

³⁸ Jennifer Lav, Nat’l Health Law Prog., *Policy Implications of Repealing the IMD Exclusion* (May 17, 2018), <https://9kqpw4dcaw91s37kozms5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/04/MedicaidIMD-Exclusion-51718docx-1.pdf>.

³⁹ Michael Botticelli and Richard Frank, *Congress needs a broader approach to address opioid epidemic*, THE HILL (June 10, 2018), <https://thehill.com/opinion/healthcare/391544-congress-needs-a-broader-approach-to-address-opioid-epidemic>.

⁴⁰ *Id.*

⁴¹ Madeline Guth et al., KFF, *The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020* 9 (2020), <https://www.kff.org/affordable-care-act/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/>.

visits increased for states that expanded Medicaid.⁴² Medicaid expansion was associated with improved access to care and medication among persons with depression, even in areas with relative shortages of mental health professionals.⁴³ Florida has left millions of federal dollars on the table, including opportunities for enhanced federal medical assistance percentage, by refusing to adopt the expansion, which it can do without the need for a waiver.

4. Florida's Request for Extended Stays Risks Increasing Unnecessary Institutionalization.

The risks highlighted above are exacerbated by the length of stays that Florida proposes. Florida requests 90 days of FFP, which is a substantial departure from CMS' current 30-day average length of stay limit.⁴⁴ Florida fails to articulate any average length of stay and instead focuses on a maximum of 90 days. CMS has consistently required states to adhere to a 30-day average length of stay for SUD and mental health and a 60-day absolute maximum stay for mental health.⁴⁵ Florida's application provides no explanation or support for its premise that stays over 60 days would reduce readmissions or further its goals.

This request for an increased length of stay is especially concerning for beds reserved for children and adults *following* crisis stabilization, where Florida's application lacks concrete information about what services these units provide, whether and why they qualify as IMDs, and why a longer stay or step-down would be necessary.⁴⁶ If people

⁴² Josuha Beslau et al., *Impact of the Affordable Care Act Medicaid Expansion on Utilization of Mental Health Care*. 58 MED CARE 757 (2020), <https://pubmed.ncbi.nlm.nih.gov/32732786/>.

⁴³ Carrie E. Fry & Benjamin D. Sommers, *Effect of Medicaid Expansion on Health Insurance Coverage and Access to Care Among Adults With Depression*, 69 PSYCHIATRIC SERVS. 1146 (2018), <https://doi.org/10.1176/appi.ps.201800181>.

⁴⁴ CMS, Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Demonstration Opportunity Technical Assistance Questions and Answers (Nov. 4, 2019), <https://www.medicaid.gov/media/40711>.

⁴⁵ *Id.*

⁴⁶ See 42 C.F.R. § 435.1010 ("Institution for mental diseases means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.); *see also* CMS, State Medicaid Manual § 4390.

remain in crisis stabilization units or inpatient facilities longer than clinically necessary because they lack services to support stabilization upon discharge, housing to discharge to, mobile response team to stabilize them at home, and peer support structures to sustain recovery, the solution is not to authorize 90 days of institutional placement. Yet Florida has not given sufficient information about these facilities to permit analysis of its request for additional funding for them.

As a practical matter, FFP for longer term stays could make it more difficult to leave. Individuals who spend more than a month or two in a facility may lose housing, either because they have been absent for too long and thus in violation of their lease, or because they can no longer pay their rent. Loss of housing often means loss of home possessions, including furniture and other basic living items. Reacquiring these items can be a significant financial barrier to housing post-institutionalization. If individuals were working prior to entering the IMD, they may lose their jobs. For these and other reasons, a longer length of stay is also associated with more lost community connections, which can threaten ongoing community placement and integration with the community.

Furthermore, allowing FFP for IMDs, especially for up to 90 days, risks undermining hard-won civil rights for people with disabilities and decades of federal policy initiatives stressing the importance of increasing community integration. IMDs are, by definition, residential settings where individuals with disabilities receive services, and decisions regarding funding for services in IMDs will inevitably have an impact on where people with disabilities receive services. In passing the Americans with Disabilities Act, Congress found that “historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem.”⁴⁷ Moreover, as Secretary Kennedy has noted, institutions can “confine[] people with disabilities to be ‘condemned to a life without hope,’” and “empowering people . . . to live healthy, productive lives in their communities” brings “Make America Healthy Again to life.”⁴⁸ Allowing FFP for IMDs does not allow people with disabilities to live the healthy and productive lives that they deserve.

⁴⁷ 42 U.S.C. § 12101.

⁴⁸ Dep’t of Health and Human Servs., “HHS’ Office for Civil Rights Works with North Carolina to Help Young Adult Living in a Hospital Move to the Community,” (June 23, 2025), <https://www.hhs.gov/press-room/ocr-nc-dhhs-agreement-olmstead.html>

D. Florida Does Not Adequately Explain if It Is Seeking FFP for Services Provided to Residents of IMDs that Are Qualified Residential Treatment Programs (QRTPs) and Residential SUD Facilities for Youth.

It is unclear whether Florida is requesting FFP for children receiving residential SUD services, for children in Qualified Residential Treatment Programs (QRTPs), or both. First, we object to the lack of transparency and public notice regarding FFP for these settings. Second, the Secretary lacks the authority to create new exceptions to the IMD exclusion for child-serving settings outside of the formal rulemaking process.

Florida indicated a plan to request FFP for “Medicaid enrollees under the age of 21 . . . when receiving residential SUD or QRTP services” in its state level notice, but then does not mention QRTPs in its federal demonstration application, or explain the discrepancy.⁴⁹ Federal regulations require states seeking a demonstration project to provide a state public notice process, and the public notice must include “a comprehensive description of the demonstration . . . that contains a sufficient level of detail to ensure meaningful input from the public, including . . . [t]he program description, goals, and objectives to be implemented or extended under the demonstration project, including a description of the current or new beneficiaries who will be impacted by the demonstration.”⁵⁰ To the extent Florida seeks coverage of services in QRTPs that are IMDs, the state has failed to give sufficient notice and the request should be rejected.

Furthermore, the Secretary does not have authority to approve FFP for individuals under age 21 in QRTPs or in residential SUD facilities that are IMDs. Congress has already prescribed the settings that are carved out of the IMD exclusion for youth and articulated the process by which the Secretary can add additional settings. Pursuant to 42 U.S.C. § 1396d(a)(16), states are authorized to obtain FFP for inpatient psychiatric hospital services for individuals under 21 (often referred to as the “psych under 21” or “psych 21” benefit), as defined in 42 U.S.C. § 1396d(h). In turn, 42 U.S.C. § 1396d(h) defines these services as “inpatient services which are provided in an institution (or

⁴⁹ *Florida 1115 IMD Application* at 26; *see also id.* at 19 (stating that “this demonstration will include all eligible individuals ages 21-64 (and under 21 where applicable) who are eligible for Medicaid and do not impose any additional eligibility criteria,” but failing to provide any additional explanation.

⁵⁰ 42 C.F.R. § 431.408(a)(1)(i)(A).

distinct part thereof) which is a psychiatric hospital . . . or in another inpatient setting *that the Secretary has specified in regulations.*"⁵¹ Through regulation, the Secretary has specified three settings that would normally be considered IMDs as eligible for FFP for the provision of inpatient behavioral health treatment for individuals under 21: a psychiatric hospital; a psychiatric unit of a general hospital; and a psychiatric residential treatment facility (PRTF).⁵² If the Secretary wishes to authorize additional settings under the "psych 21" benefit, the law requires the Secretary to do so via the formal rulemaking process.

III. Conclusion

For the above legal and policy reasons, we ask the Secretary to reject Florida's proposal. If you have questions about these comments, please feel free to contact Steven Schmidt at schmidt@healthlaw.org or Brit Vanneman at vanneman@healthlaw.org.

Sincerely,



Jennifer Lav
Director, Disability Practice Area

⁵¹ 42 U.S.C. § 1396d(h)(1)(A) (emphasis added).

⁵² 42 C.F.R. § 441.151.