The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	CS/SB 1354
INTRODUCER:	Children, Families, and Elder Affairs Committee and Senator Trumbull
SUBJECT:	Behavioral Health Managing Entities
DATE:	March 26, 2025 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Kennedy	Tuszynski	CF	**Fav/CS**
2.			AHS	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1354 requires the Department of Children and Families (DCF) to contract for biennial operational and financial audits of the seven behavioral health managing entities (ME) that are charged with coordinating the state's safety-net mental health and substance use disorder services for the uninsured and underinsured. A final report must be submitted to the Governor and Legislature by December 1, 2025.

The bill requires MEs to submit all data required by statute, rule or contract to be reported in a standardized electronic format specified by the DCF.

The bill also establishes performance standards, requiring MEs to report on service accessibility, community behavioral health outcomes, diversion from acute care, and integration with child welfare services. MEs must track key behavioral health performance metrics, including high-utilizer rates, post-hospitalization outpatient care, appointment wait times, and emergency room visits for behavioral health issues. It requires the DCF to post ME performance information to its website by the 15th of every month.

The bill has a significant negative fiscal impact on the government and private sector. *See* Section V. Fiscal Impact Statement.

This bill takes effect July 1, 2025.

II. Present Situation:

Mental Health and Mental Illness

Mental health is a state of well-being in which the individual realizes his or her own abilities can cope with normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community.[1] The primary indicators used to evaluate an individual's mental health are:[2]

- Emotional well-being: perceived life satisfaction, happiness, cheerfulness, peacefulness;
- Psychological well-being: self-acceptance, personal growth including openness to new experiences, optimism, hopefulness, purpose in life, control of one's environment, spirituality, self-direction, and positive relationships; and
- Social well-being: social acceptance, beliefs in the potential of people and society as a whole, personal self-worth and usefulness to society, sense of community.

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning.[3] Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being. Mental illness affects millions of people in the United States each year. More than one in five adults lives with a mental illness.[4] Young adults aged 18-25 had the highest prevalence of any mental illness[5] (36.2%) compared to adults aged 26-49 (29.4%) and aged 50 and older (16.8%).[6]

Mental Health Safety Net Services

DCF administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment and recovery for children and adults who are otherwise unable to obtain these services. SAMH programs include a range of prevention, acute interventions (e.g., crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.

Behavioral Health Managing Entities

In 2001, the Legislature authorized the DCF to implement behavioral health MEs as the management structure for the delivery of local mental health and substance abuse services.[7] The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature

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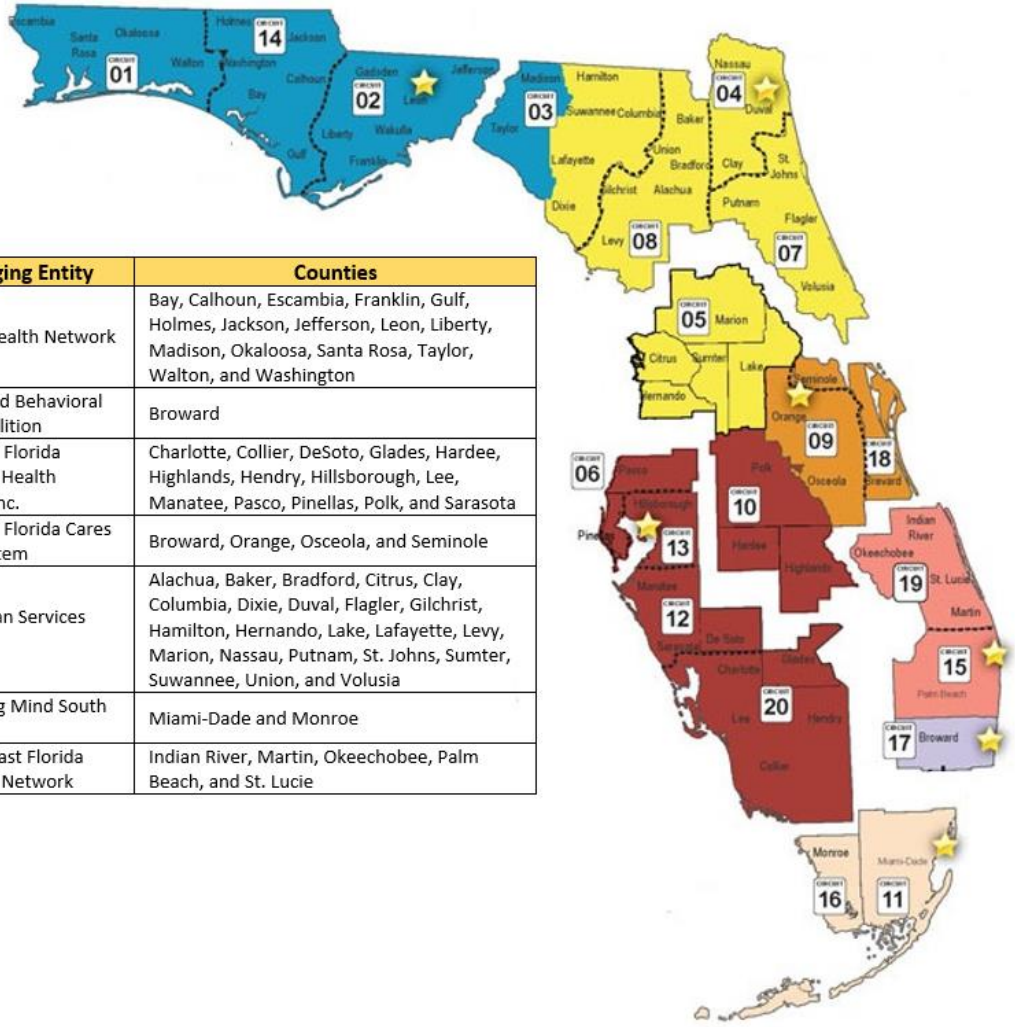
[1] World Health Organization, *Mental Health: Strengthening Our Response*, available at: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response (last visited last visited 3/7/25).
[2] Centers for Disease Control and Prevention, *Mental Health Basics*, available at: http://medbox.iiab.me/modules/en-cdc/www.cdc.gov/mentalhealth/basics.htm (last visited last visited 3/7/25).
[3] *Id.*
[4] National Institute of Mental Health (NIH), *Mental Illness*, available at: https://www.nimh.nih.gov/health/statistics/mental-illness (last visited last visited 3/7/25).
[5] Any mental illness (AMI) is defined as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment (e.g., individuals with serious mental illness).
[6] National Institute of Mental Health (NIH), *Mental Illness*, available at: https://www.nimh.nih.gov/health/statistics/mental-illness (last visited March 14, 2025).
[7] Ch. 2001-191, Laws of Fla.

authorized the DCF to implement MEs statewide.[8] MEs were fully implemented statewide in 2013, serving all geographic regions.

The DCF currently contracts with seven MEs for behavioral health services throughout the state. These entities do not provide direct services; rather, they allow the department's funding to be tailored to the specific behavioral health needs in the various regions of the state. The regions are divided as follows:[9]



Managing Entity	Counties
NWF Health Network	Bay, Calhoun, Escambia, Franklin, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Walton, and Washington
Broward Behavioral Health Coalition	Broward
Central Florida Behavioral Health Network, Inc.	Charlotte, Collier, DeSoto, Glades, Hardee, Highlands, Hendry, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, and Sarasota
Central Florida Cares Health System	Broward, Orange, Osceola, and Seminole
Lutheran Services Florida	Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lake, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia
Thriving Mind South Florida	Miami-Dade and Monroe
Southeast Florida Behavioral Network	Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie

In the latest comprehensive, multiyear review of the revenues, expenditures, and financial positions of the MEs,[10] these contracts totaled $1.083 billion for FY 2022-23, with $919 million

[8] Ch. 2008-243, Laws of Fla.
[9] DCF, *Managing Entities*, available at: https://www.myflfamilies.com/services/samh/providers/managing-entities (last visited March 14, 2025).
[10] DCF, *A Comprehensive, Multi-Year Review of the Revenues, Expenditures, and Financial Positions of the Managing Entities Including a System of Care Analysis*, p. 5, available at https://myflfamilies.com/document/57451, (last visited March 21, 2025); Section 394.9082(4)(I), F.S.

spent on direct services.[11] MEs subcontract with community providers to serve clients directly; this allows services to be tailored to the specific behavioral health needs in the various regions of the state.[12]

In FY 2022-23, in the aggregate, DCF reported serving 243,403 unduplicated behavioral health clients.[13]

Coordinated System of Care

Managing entities are required to promote the development and implementation of a coordinated system of care.[14] A coordinated system of care means a full array of behavioral and related services in a region or community offered by all service providers, participating either under contract with a managing entity or by another method of community partnership or mutual agreement.[15] A community or region provides a coordinated system of care for those with a mental illness or substance abuse disorder through a no-wrong-door model, to the extent allowed by available resources. If funding is provided by the Legislature, the DCF may award system improvements grants to managing entities.[16] MEs must submit detailed plans to enhance crisis services based on the no-wrong-door model or to meet specific needs identified in the DCF's assessment of behavioral health services in this state.[17] The DCF must use performance-based contracts to award grants.[18]

There are several essential elements which make up a coordinated system of care, including:[19]

- Community interventions;
- Case management;
- Care coordination;
- Outpatient services;
- Residential services;
- Hospital inpatient care;
- Aftercare and post-discharge services;
- Medication assisted treatment and medication management; and
- Recovery support.

A coordinated system of care must include, but is not limited to, the following array of services:[20]

- Prevention services;
- Home-based services;
- School-based services;

[11] *Id.* at 11.
[12] Department of Children and Families, *Managing Entities*, available at https://www.myflfamilies.com/services/samh/provIders/managing-entities, (last visited March 16, 2025).
[13] S*upra*, Note 10, p. 14.
[14] Section 394.9082(5)(d), F.S.
[15] Section 394.4573(1)(c), F.S.
[16] Section 394.4573(3), F.S.
[17] *Id.*
[18] *Id.*
[19] Section 394.4573(2), F.S.
[20] Section 394.495(4), F.S.

- Family therapy;
- Family support;
- Respite services;
- Outpatient treatment;
- Crisis stabilization;
- Therapeutic foster care;
- Residential treatment;
- Inpatient hospitalization;
- Case management;
- Services for victims of sex offenses;
- Transitional services; and
- Trauma-informed services for children who have suffered sexual exploitation.

The DCF must define the priority populations which would benefit from receiving care coordination.[21] In defining priority populations, the DCF must consider the number and duration of involuntary admissions, the degree of involvement with the criminal justice system, the risk to public safety posed by the individual, the utilization of a treatment facility by the individual, the degree of utilization of behavioral health services, and whether the individual is a parent or caregiver who is involved with the child welfare system.

MEs are required to conduct a community behavioral health care needs assessment once every three years in the geographic area served by the managing entity, which identifies needs by sub-region.[22] The assessments must be submitted to DCF for inclusion in the state and district substance abuse and mental health plan.[23] In addition to the needs assessment, the ME is generally required to also:

- Determine the optimal array of services to meet the community's needs.
- Promote a coordinated system of care.
- Assist counties in development of designated receiving systems and transportation plans.
- Develop strategies to divert persons with mental illness or substance abuse from criminal and juvenile justice systems and integrate behavioral health services with the child welfare system.
- Develop a compressive network of qualified providers to deliver services.
- Monitor network provider performance and compliance with contract requirements.[24]

Under Florida Administrative Code, MEs are required to implement a Care Coordination Policy applicable to all subcontracted service providers.[25] This policy must ensure that services are delivered based on eligibility, clinical appropriateness, individual need, and with fiscal accountability.[26] The rule requires care coordination policies that reduce, manage, and eliminate waitlists, support service planning for individuals with co-occurring substance use and mental health disorders and promote the use of clinical screening and assessment tools to determine the

[21] Section 394.9082(3)(c), F.S.
[22] Section 394.9082(5)(b), F.S.
[23] Section 394.75(3), F.S.
[24] Section 394.9082(5), F.S.
[25] Rule 65E-14.014, F.A.C.
[26] *Id.*

appropriate level of care. In addition, the policy must ensure that individuals are served in the least restrictive setting appropriate to their clinical needs and that system changes are monitored to improve service efficiency. The rule also calls for the use of outcome data to inform service delivery and to support continuous improvement across the behavioral health system.

Data Collection and Reporting by Managing Entities

MEs are responsible for collecting and reporting specific data to the DCF.[27] Current law requires MEs to establish performance standards related to:

- Service Reach: The extent to which individuals in the community receive services, including parents or caregivers involved in the child welfare system who need behavioral health services.
- Community Behavioral Health Improvement: The overall improvement in the behavioral health of the community.
- Individual Progress: The improvement in functioning or progress in recovery of individuals served by the ME, using person-centered measures tailored to the population.
- Diversion Strategies: The success of strategies to divert admissions from acute levels of care, jails, prisons, and forensic facilities, including metrics on clients experiencing multiple admissions to such facilities.
- Integration with Child Welfare: The effectiveness of integrating behavioral health services with the child welfare system.
- Housing Needs: Addressing the housing needs of individuals being released from public receiving facilities who are homeless.
- Consumer and Family Satisfaction: Levels of satisfaction among consumers and their families.
- Community Engagement: The level of engagement with key community constituencies, such as law enforcement agencies, community-based care lead agencies, juvenile justice agencies, courts, school districts, local government entities, hospitals, and other relevant organizations.

Florida Administrative Code further, establishes standards for service providers under direct contract with the DCF or subcontract with an ME.[28] It requires providers to report services using defined Substance Abuse and Mental Health (SAMH) covered services and to adhere to specified measurement and reporting standards.

MEs are also required by contract to submit multiple reports, forms, and documents at specific intervals to the DCF.[29] Some of these include Regional Planning Documents, Provider Tangible Property Inventory, Triennial Needs Assessments, Managing Entity Annual Business Operations Plans (including SAMHTF Discharge Reintegration Plan, Triennial Needs Assessment, Care Coordination Plan, Quality Assurance Plan, Assisted Living Facility (ALF)-LMH Plan, Annual Network Service Provide Monitoring Plan), Enhancement Plan, Care Coordination Plan, Quality

[27] Section 394.9082(7), F.S.
[28] Rule 65E-14.021, F.A.C
[29] Department of Children and Families, Managing Entity Standard Contract, *Exhibit C3*, available at: https://www.myflfamilies.com/document/30496 (last visited 3/21/25).

Assurance Plan, Fraud and Abuse Prevention Protocol, Network Services Provider Monitoring Plan, Information Technology Plan, etc.[30]

MEs are also required by contract to submit multiple minimum performance measures.[31] This includes measures of things such as:

- On-site performance monitoring of network providers.
- Service level compliance.
- Federal block grant implementation.
- Network service provider measures.
- Corrective action for performance deficiencies.[32]

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 394.9082(3), F.S., to require the DCF to contract for biennial operational and financial audits of each ME. These audits must include:

- Business practices, personnel, financial records, provider payments, expenditures, referral patterns, and provider network adequacy.
- Services administered, the method of provider payment, expenditures, outcomes, and other information as determined by the department.
- Referral patterns, including ME volume, provider assignments, services referred, length of time to obtain services, and key referral performance measures.
- Provider network adequacy and provider network participation in the DCF's available bed platform, the Opioid Data Management System, the Agency for Health Care Administration Event Notification Service, and other required provider data submissions.

The audits must review expenditure and claims of each ME must analyze services funded by MEs rendered to individuals who are also Medicaid beneficiaries, to assess the extent to which MEs are funding Medicaid-covered services, and also compare:

- Services administered through each ME;
- Outcomes of ME expenditures; and
- Any other information as determined by the DCF.

The audit must include recommendations to improve transparency of system performance, to include metrics and criteria used to measure each MEs, performance and outcomes, and the format and method used to collect and report data.

A final report summarizing audit findings and recommendations must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2025.

[30] *Id.*
[31] Department of Children and Families, Managing Entity Standard Contract, Exhibit E, available at: https://www.myflfamilies.com/document/52831 (last visited 3/21/25).
[32] *Id.*

The bill amends s. 394.9082(5), F.S., to require an ME to submit all required information to the DCF in a standardized electronic format to ensure interoperability and facilitate data analysis. This format must meet all of the following criteria:

- Provider payments must be reported using a standardized format for electronic data interchange.
- Organized into discrete, machine-readable data elements that allow for efficient processing and integration with other datasets.
- Comply with established protocols specified by the DCF.
- Compatible with automated systems to enable downloading, parsing, and combining data.
- Pass validation checks to confirm adherence to required data structure and format.

The bill requires MEs to submit all documents required under the contract for routine submission in an electronic format that supports accurate text recognition and data extraction. Documents must be accompanied by metadata to ensure proper organization, processing, and integration. This metadata must include all of the following:

- Descriptive and unique document name;
- Upload date;
- Predefined classification;
- Relevant identifiers; and
- Submitter information.

The bill amends s. 394.9082(7), F.S., to require MEs to collect and submit data on persons served, service outcomes, and costs. MEs are mandated to collect and submit data to the DCF regarding persons served, service outcomes, service costs, and other required data.

The DCF will evaluate ME performance and overall progress in meeting community behavioral health needs based on person-centered outcome measures that reflect national standards, where possible.

The bill requires MEs to submit the following new specific measures to the DCF:

- High Utilizers: The number and percentage of high utilizers of crisis behavioral health services.
- Post-Hospitalization Services: The number and percentage of individuals referred to outpatient behavioral health services within seven days after discharge from a receiving or treatment facility for behavioral health-related issues.
- Appointment Wait Times: The average wait time for initial appointments for behavioral health services, categorized by the type of service.
- Urgent Appointments: The number and percentage of individuals with significant behavioral health symptoms seeking urgent noncrisis acute care able to schedule urgent behavioral health appointments within 1 business day after initial contact with provider.
- Medication Errors
- Adverse Incidents
- Co-occuring Conditions: the number of individuals receiving integrated care.
- Emergency Department Visits: The number and percentage of emergency department visits per capita for behavioral health-related issues.

- Community Discharge Placements: The percentage of individuals discharged from a receiving or treatment facility who successfully transition to ongoing services at the appropriate level of care.
- Emergency Department Readmissions: The rate of readmissions to an emergency department due to behavioral health issues or to crisis within 30 days of discharge from inpatient or outpatient behavioral health services.
- Average Length of Stay: The average length of stay for inpatient behavioral health services.

Section 2 of the bill provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The bill does not require cities and counties to expend funds or limit their authority to raise revenue or receive state-shared revenues as specified by Article VII, s. 18, of the State Constitution.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None Identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The Managing Entities and Community Providers

Indeterminate, likely significant negative fiscal impact on private-sector managing entities and community providers. The bill proposes expanded reporting and audit requirements based on claims processing. This likely does not align with current behavioral health ME funding and reporting systems, which do not rely on diagnosis-based or Medicaid billing structures. Additionally, the bill introduces new performance

metrics and audit expectations that may exceed current data capabilities. Adapting to this model will likely require system updates, technical support, and staff training.

C. Government Sector Impact:

Determinate significant negative fiscal impact on government sector. The bill requires the DCF to procure auditing services for the operational and financial audits of its seven Managing Entity contracts. The DCF estimates a fiscal impact of $3,000,000.[33]

Below is DCF's estimated cost breakdown for implementing this new system. Cost figures are based on the assumptions provided (e.g., number of contractors, Cloud infrastructure, professional services, etc.). IT System Modernization is estimated at $6,900,000 nonrecurring.[34]

Item	Cost	Description
IT Contractors (8)	$1,920,000	- 8 contractors (data architects, developers, analysts, report developers) - $120/hour * 2,000 hours each = $240,000 per FTE
Cloud Infrastructure & Security	$800,000	- Hosting, cloud storage, cybersecurity measures
Business Advisory & Project Management	$1,500,000	- Oversight, requirement gathering, stakeholder engagement, risk management
Training, OCM for MEs	$700,000	- Training managing entities on new processes, data formats, portal usage
Upgrading ME Systems	$1,000,000	- Grants or funding assistance to help MEs modernize/replace legacy systems to ensure interoperability
Additional Software, licensing's	$1,000,000	- Integrates Edifecs with new portal, back-end APIs, data ingestion, and partner credentialing
Total	$6,920,000	

Estimated Recurring Costs are estimated at $3,900,000 for maintenance and operation.[35]

The current platform used by the DCF for managing mental health and substance abuse data is the Financial and Services Accountability Management System (FASAMS). The data reporting provisions introduced in the proposed legislation would necessitate extensive modifications to the existing system.[36] The new platform will require vendor support, infrastructure, training, and staffing and is expected to take 12 to 18 months to complete.[37]

[33] Florida Department of Children and Families, *SB 1354 (2025) Agency Analysis*, 3/7/25, p.7 (on file with the Children, Families, and Elder Affairs Committee).
[34] *Id*, p. 9
[35] *Id.*
[36] *Id*., p. 8
[37] *Id.*

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 394.9082 of Florida Statute.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Children, Families, and Elder Affairs on March 25, 2025:
The CS makes the following changes:

- Makes the operational and financial audits biennial instead of annual.
- Requires all currently reported data by MEs (required by statute, rule, and contract) to be submitted in an electronic format specified by the DCF.
- Requires the DCF to post ME performance information (based on the data collected) to its website by the 15th of every month.
- Generally, clarifies the data requested for evaluation for performance is data that the ME's have access to, not general claims and private provider systems data as previously interpreted.

B. Amendments:

None.