Advancing Florida's Behavioral Health System

An Assessment of Publicly Funded Services, Capacity, and Cost Management Approaches

June 30, 2026

AUTHORED BY

Kathleen Moore, PhD
Abigail Shockley, MPH, CPH
T. Freeman Gerhardt, PhD
M. Scott Young, PhD
Jacob Gray, PhD
Melissa Carlson, MRA
Mary Kleinman, MS

UNIVERSITY of SOUTH FLORIDA
College of Behavioral & Community Sciences
Criminal Justice, Mental Health, and Substance Abuse Techincal Assistance Center

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Author List

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Executive Summary

Florida has made substantial progress in strengthening its publicly funded behavioral health system through strategic investments in community-based care, crisis services, behavioral health integration, and regional coordination. Today, approximately 1.6 million Floridians receive publicly funded mental health and substance use services through Medicaid, Department of Children and Families (DCF), Department of Education, Department of Corrections, Department of Juvenile Justice, Medicare, and other publicly supported programs. These services represent one of the state's largest public health investments and play an essential role in improving health outcomes, supporting public safety, reducing homelessness, and lowering avoidable healthcare utilization.

Despite this progress, behavioral health needs continue to place significant demands on Florida's healthcare and public safety systems. In 2024 alone, Florida experienced more than 5,500 fatal drug overdoses, nearly 83,000 emergency medical responses to overdoses, over 116,000 emergency department visits related to mental illness, and more than 64,000 emergency department visits associated with alcohol misuse or nonfatal drug overdoses. These figures underscore the importance of maintaining a behavioral health system that emphasize prevention, early intervention, timely treatment, recovery support, and effective crisis response.

Pursuant to section 1004.44, Florida Statutes, the Louis de la Parte Florida Mental Health Institute was directed to assess Florida's publicly funded behavioral health system by identifying available services, evaluating provider capacity, examining approaches to cost management, and comparing Florida's behavioral health expenditures with national trends. This report synthesizes publicly available information from federal and state agencies, recent literature, and administrative data to provide an overview of Florida's behavioral health infrastructure and identify opportunities for continued improvement.

Major Findings

Florida has established a strong statewide behavioral health infrastructure.

The state has developed a comprehensive publicly funded behavioral health network anchored by Medicaid and DCF's Managing Entity system. Florida has invested in integrated primary and behavioral healthcare, Certified Community Behavioral Health Clinics, Federally Qualified Health Centers, Mobile Response Teams, crisis stabilization services, designated receiving systems, and coordinated regional behavioral health planning. These investments closely align with nationally recognized best practices emphasizing community-based treatment, crisis response, and integrated care.

Florida continues to rely heavily on its public behavioral health system to serve uninsured and underinsured residents.

Unlike many states, Florida has not adopted Medicaid expansion and has relatively limited county-based behavioral health coverage programs. Consequently, DCF's Managing Entities serve as the state's primary behavioral health safety net for uninsured and underinsured individuals. This system plays a critical role in ensuring access to treatment for residents who would otherwise face significant barriers to care.

Significant progress has been made in accountability and quality oversight.

Florida utilizes nationally recognized performance measures across Medicaid and Medicare while DCF maintains extensive contractual performance requirements, financial oversight, independent audits, and outcome monitoring for Managing Entities. These systems demonstrate a strong commitment to fiscal stewardship and accountability for public investments.

Opportunities exist to improve transparency of behavioral health financing.

Although behavioral health represents a substantial public investment, Florida currently lacks a comprehensive public accounting of behavioral health expenditures across Medicaid, commercial insurance, Medicare, DCF, and other funding sources. Similarly, publicly available data do not consistently report expenditures by service setting or level of care, limiting the state's ability to compare investments, evaluate return on investment, or assess system-wide utilization patterns.

Provider capacity varies across Florida.

While many regions demonstrate robust provider networks, geographic variation in workforce availability, including across disciplines, and service capacity persists, particularly for specialized behavioral health providers. Continued workforce development, recruitment, retention, and strategic deployment remain essential to ensuring equitable access statewide.

Florida is well positioned to leverage emerging federal opportunities.

Florida's recent submission of a Section 1115 Medicaid demonstration waiver to enable coverage for services within Institutions for Mental Disease (IMDs), reflects continued efforts to expand behavioral health treatment options and strengthen care transitions. If approved, this initiative may improve access to residential treatment, enhance continuity of care, and further strengthen the state's behavioral health continuum.

Strategic Opportunities

The findings identify several opportunities that could further strengthen Florida's behavioral health system while improving accountability and maximizing the impact of public investments.

Priority opportunities include:

- Expanding transparency of behavioral health expenditures and utilization across funding sources.
- Strengthening statewide workforce planning using regional provider capacity data.
- Increasing access to community-based prevention, outpatient treatment, recovery support, and crisis services in underserved areas.
- Evaluating comparative effectiveness and return on investment of behavioral health programs to guide future funding decisions.
- Enhancing public reporting of quality, utilization, and system performance indicators.
- Continuing to pursue innovative Medicaid financing strategies that improve access while promoting fiscal sustainability.
- Strengthen statewide implementation and enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA) by increasing oversight, transparency, and monitoring of behavioral health benefit design and utilization management practices.
- Strengthening coordination across state agencies and publicly funded behavioral health systems to improve continuity of care and reduce duplication of services.

Looking Forward

Florida has established a strong foundation for delivering publicly funded behavioral health services and continues to make meaningful progress toward a modern, community-based system of care. Continued emphasis on transparency, workforce capacity, data-driven decision making, and strategic investment will help ensure that behavioral health resources are deployed efficiently while improving outcomes for individuals, families, and communities.

The recommendations presented throughout this report are intended to support policymakers in strengthening Florida's behavioral health infrastructure, improving access to evidence-based services, enhancing accountability for public investments, and ensuring the long-term sustainability of the state's behavioral health system.

Chapter 1: Introduction and Charge

Background

Access to timely, high quality mental health and substance use services is a critical component of Florida's public health system. Between 2022 and 2023 an estimated 16.4% of adults in Florida had a past-year substance use disorder (SUD) and 19.9% reported a mental illness[1]. The prevalence of these conditions contributes to increased utilization of emergency responses and acute care services. Mental health (MH) and SUD not only impact public health systems but also contribute to public safety and community-sector outcomes, increasing both cost and demand on hospital and law enforcement systems. Although overdose rates and emergency department (ED) visits for MH and SUD have declined in recent years, behavioral health crises contributed to the following statewide statistics in 2024:

- Fatalities: 5,501 fatal drug overdoses and 134 youth deaths by suicide[2,4]
- Emergency Medical Services (EMS) utilization: 82,954 drug overdose responses, with 29% involving suspected opioid use[2]
- Emergency Department utilization[3,4]:
    - 116,337 ED visits were for mental health disorders
    - 33,709 ED visits were for alcohol abuse
    - 31,016 ED visits were for non-fatal drug overdoses
    - 4,281 ED visits were for intentional youth self-harm injuries

This data reinforces the need for a behavioral health system capable of early identification and engagement, effective outpatient treatment, and responsive crisis services. National best practices identified by the National Academy for State Health Policy (NASHP) and

the Substance Abuse and Mental Health Services Administration (SAMHSA) emphasize a comprehensive behavioral health system that includes integrated primary and behavioral healthcare, a robust crisis service continuum, outpatient and residential treatment, recovery-support services, and wraparound or community-based supports[5,6]. Evidence consistently demonstrates that investing across the full continuum of prevention, treatment, and recovery services can reduce avoidable hospitalizations and support long-term stability. For example, integrated primary and behavioral health models have been associated with fewer ED visits and inpatient admissions as well as reduced Medicaid and commercial insurance costs[7,8,9]. Access to outpatient behavioral health services has similarly been linked to reductions in overall medical and pharmacy expenditures[10]. Crisis services (e.g., crisis intervention, mobile crisis teams, crisis stabilization units) are also associated with fewer inpatient admissions, shorter ED stays, and reduced subsequent behavioral-health ED visits[11,12,13]. At the farthest end of this continuum of care, residential MH and SUD treatment programs provide stabilization for individuals with high clinical needs, while community-based outpatient services provide continuity of care and recovery housing often as a more cost-effective alternative to traditional transitional care and community re-entry following treatment[14]. This robust continuum, when sufficiently available within communities, supports long-term recovery of individuals with MH and SUD.

States with Strong Behavioral Health Systems

Efforts to improve behavioral health system outcomes enabled through the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA) have started to transform behavioral health funding landscapes. As states work to expand access to care, incentivize integration of primary and behavioral health care, and invest in quality care, several have emerged as leaders with greater access to care and lower prevalence of mental illness[15].

Core characteristics of how behavioral health services are financed and delivered in states with strong behavioral health systems include[16,17,18,19,20]:

- **Medicaid serves as the largest payer for behavioral health services**, accounting for approximately 20-35% of behavioral health spending where comparable expenditure data were available.
- **Outpatient behavioral health services account for the largest share of service utilization and spending** across both Medicaid state funds and commercial insurers, followed by inpatient behavioral health services.
    - Community services similarly account for a significantly greater portion of state mental health expenditures compared to state hospital services.
- **Behavioral health-related ED utilization rates are relatively low** (e.g., less than 4% of all BH spending) across payers, suggesting stronger access to outpatient and community-based care.
- **High levels of transparency in health spending**, including detailed public reporting on payer-specific expenditures by service category or care setting.
- **Strategic initiatives to improve access and financing models** for behavioral health using 1115a Medicaid Demonstration Waivers.
    - Ex: Enabling coverage for substance use and/or mental health services within Institutions for Mental Diseases (IMD)[a]
    - Ex: Medicaid coverage for incarcerated adults and youth up to 90 days pre-release

[a] The IMD exclusion is a commonly known barrier to residential and inpatient SUD treatment access for individuals covered by Medicaid. The regulation limits Medicaid reimbursement to such settings with more than 16 beds. Some states have CMS 1115(a) waivers to address this limitation for inpatient and residential behavioral health facilities.

- Ex: Integration and finance transformation (e.g., integrated primary and behavioral healthcare, testing value-based care models)

Some leading states also have state-level policies requiring residents to maintain health insurance coverage and mandating that insurance plans include MH and SUD benefits under terms no more restrictive than those applied to physical health care[21,22]. These state leaders illustrate how policy, regulatory oversight, and investment strategies can shape behavioral health system performance and outcomes. Conversely, Florida and other mid-performing states (e.g., Texas) have a greater number of affected residents with unmet treatment needs and less access to care[16].

Florida's Behavioral Health System

Coverage

In contrast to several states, Florida does not require residents to maintain health insurance coverage, nor does the state mandate that insurers provide the full continuum of MH or SUD coverage[23,24]. Instead, Florida's behavioral health coverage framework is largely shaped by federal Affordable Care Act (ACA) essential health benefit and benchmark plan requirements as well as federal MH parity protections[21]. As a result, access to behavioral health coverage is influenced more heavily by federal policy than by state-specific coverage mandates or publicly financed insurance expansions.

Florida is also only one of 10 states that has not adopted Medicaid expansion, limiting coverage options for many low-income adults[25]. Recognizing the need to address gaps in access to care, the Florida Commission on Mental Health and Substance Abuse supported the need to develop a safety-net infrastructure of care for indigent, uninsured, and underinsured individuals

seeking behavioral health services, for which the state's Managing Entity (ME) system plays an integral part in addressing. Additionally, only six of Florida's 67 counties currently participate in the Health Flex program, a county-based initiative that provides limited behavioral health coverage and services for residents with indigent status alongside other uninsured and underinsured individuals[26].

Behavioral health services make up about 29.5% of Florida's Medicaid budget, which is comparable to other states, and Medicaid is the largest state funder of behavioral health services[27]. However, publicly accessible data are not available in Florida to uniformly compare behavioral health budgets across payors (i.e., commercial, Medicaid, Medicare, and Department of Children and Families), service settings, or service types.

Services and Practices

In practice, Florida demonstrates moderate alignment with national behavioral health system best practices. The state has made substantial progress in integrating behavioral health into primary care and establishing behavioral health medical homes. For example, Florida has 47 Federally Qualified Health Centers and 21 Certified Community Behavioral Health Clinics as of 2024 (see maps in Appendix Figures)[28,29]. In addition, the Florida Pediatric Behavioral Health Collaborative embeds behavioral health services within primary care settings and builds provider capacity for screening, diagnosis, and coordinated care[30]. This approach supports early identification of behavioral health needs and facilitates coordination across service providers. Florida Medicaid managed care plans are also required to provide enhanced support for the integration and coordination of primary care and behavioral health services[31]. Network service providers, contracted through Managing Entities, demonstrate the strongest alignment of service

offerings with evidence-based practices, including integrated care, a strong crisis continuum, and community-based treatment.

Florida's crisis response and community-based care services are comprehensive. The state has strengthened its crisis continuum through investments in designated receiving systems, Managing Entities, Mobile Response Teams, regional interagency crisis collaborations, and enhanced coordination with the 988 Suicide and Crisis Lifeline. Community-based outpatient services and individualized in-home supports further demonstrate alignment with NASHP's framework for accessible, community-based behavioral health infrastructure. Florida's out-of-home treatment settings include inpatient (e.g., facilities for psychiatric and substance use treatment) and residential facilities (e.g., group homes and therapeutic foster care). These provide additional support for individuals with more intensive behavioral health needs.

Florida has also recently pursued additional strategies intended to expand flexibility within its behavioral health continuum through Medicaid financing mechanisms[32]. In January 2026, Florida submitted a Section 1115 demonstration application to the Centers of Medicaid and Medicare Services (CMS) seeking authority related to services provided in IMDs, with a focus on improving access to addiction receiving facilities, psychiatric residential, and short-term residential behavioral health treatment along with strengthening care transitions, including care coordination and continuity of treatment plans across settings. The proposal emphasizes use of community-based services and care coordination to support continuity of care before, during, and following residential treatment episodes, while also incorporating monitoring and quality measures intended to evaluate access and outcomes. If approved, implementation of the demonstration may provide additional opportunities to support individuals with more intensive behavioral health needs and strengthen Florida's existing behavioral health continuum. Section

1115 waivers have increasingly been used to support services that historically faced reimbursement barriers, including substance use disorder treatment delivered in Institutions for Mental Diseases (IMDs), providing services to justice-involved populations ahead of re-entry to the community, expanding community-based behavioral health services, crisis services, and testing integrated care models[33]. These policy mechanisms have allowed states to shift resources toward more comprehensive continuums of care that include prevention, treatment, and recovery supports rather than relying primarily on crisis-driven and uncompensated care approaches[34].

Publicly Supported Behavioral Health Services in Florida

Publicly supported behavioral health services refer to the range of MH and SUD services that are financed, administered, or overseen by federal, state, or local entities. These services may be funded through Medicaid, state and county general revenue appropriations, federal block and discretionary grants, agency specific funding streams, or local safety net initiatives. Public support also includes behavioral health services provided within state-operated systems in sectors impacted by behavioral health issues (e.g., Department of Education, Department of Law Enforcement).

It is estimated that around 1.6 million individuals in the state are recipients of publicly funded behavioral health services, the foundation of which is supported through Medicaid and Department of Children and Families' (DCF) Office of Substance Abuse and Mental Health (SAMH). The Agency for Health Care Administration (AHCA) manages Florida Medicaid, which delivers most behavioral health benefits through Statewide Medicaid Managed Care (SMMC/MMA) under capitated (e.g. fixed rate) contracts with health plans. To support coverage gaps for under and uninsured populations, DCF SAMH contracts with seven regional Managing Entities that plan and coordinate community MH and SUD services. DCF SAMH also contracts

directly with agencies to support special systems level funding initiatives, such as the Florida Center for Behavioral Health Workforce (s.1004.44, F.S) and the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program, (s.394.657, F.S.).

However, several other state agencies offer supplemental financing and deliver behavioral health services, including the Department of Education (DOE), Department of Corrections (DOC), Department of Juvenile Justice (DJJ), and the Department of Veterans' Affairs (DVA). For example, the Marjory Stoneman Douglass Act mandates the expansion of school-based mental health services[35]. In addition, a small number of county indigent care programs fund services for uninsured residents, and some state funds go towards Medicare, to support MH and SUD services. Table 1 provides estimates for the number of individuals served by funder and their estimated expenditures.

Table 1. Individuals Served by Agency and Estimated Expenditures

Agency	**Number of Individuals Served**	**Estimated MH/SUD Budget**
Agency for Health Care Administration	410,210[36]*	3.3B[3636]*
Department of Children and Families	237,606[37]	1.5B[27]
Department of Education	226,087[37]	180M[38]
Department of Juvenile Justice	10,377[37]	81.6M[39]
Department of Corrections	67,129[37]	54.2M[40]

Medicare	663,578[41]**	-

Note: *This estimate is based on a set of behavioral health procedures codes pulled from publicly available Fee-For-Service (FFS) schedules, which is not all-inclusive, though the reported data included claims and budget for this set of codes within managed care plans. It is estimated that the number of individuals served and estimated budget are higher. **The number of Medicare individuals served represents the number of Medicare beneficiaries with a serious mental illness as there is no publicly available data that identifies this population in Florida. It is estimated that this number is higher given missing data on individuals with SUDs. Based on publicly available data the year of reference is not consistent across each funding source. This is an opportunity for future inquiry.

Benchmarks of Success Across Funding Streams

Each funding stream maintains its own performance measures, standardized reporting requirements, and quality improvement/enhancement plans, with some overlap across systems. In general, Florida utilizes nationally standardized measures for behavioral health in Medicaid, including relevant measures from the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS), which tracks indicators such as follow-up care, treatment engagement, and medication management. Medicare similarly utilizes HEDIS measures, including a Medicare-specific Health Outcomes Survey (HOS) to track members' physical and mental health status. DCF's managing entity (ME) contracts complement these measures with social determinants of health indicators (e.g., housing stability, employment), treatment completion and rearrest data and subcontract-specific outcomes of interest to evaluate the success of behavioral health providers that are funded for special pilots or initiatives.

Approaches to Fiscal Stewardship

AHCA's Comprehensive Quality Strategy establishes system-level goals (e.g., targeted rates for admissions, readmissions, ED visits) and monitors key behavioral health indicators, such as follow-up care and treatment engagement, to support improved outcomes and more efficient use of funds. To ensure compliance, AHCA may impose sanctions for non-compliance with minimum standards or assess liquidated damages when managed care plans fail to meet contractual performance standards, reinforcing fiscal and programmatic accountability. However, data on the frequency or volume of sanctions for non-compliance were unavailable to review for inclusion in this report.

Similarly, DCF is legislatively required to enforce benchmarks for success across its behavioral health service network. These requirements include conducting biennial multi-year reviews of managing entity revenues and expenditures and requesting biennial financial and operational audits of all managing entities. These audits assess business practices, expenditures and claims, services administered, and administrative data systems. This legislation also parallels Medicaid, requiring reporting data related to diversion from inpatient and ED utilization, high utilizer tracking, and posthospitalization outpatient follow up. Within each DCF contract, financial penalties may be issued for failure to meet or comply with these standards.

Current Report

Following §1004.44, Fla. Stat (2025), the Louis de la Parte Florida Mental Health Institute (FMHI) was charged with analyzing behavioral health services provided through publicly funded programs in the state of Florida. This report primarily draws on data and reports produced within the past three years to examine service coverage across programs, patterns of utilization and expenditures, approaches to cost management, the availability of providers, and where available, state workforce capacity with regional considerations. By examining the scope,

coverage, cost, and capacity of these services, this report aims to assess how well Florida's behavioral health system is positioned to meet current needs and respond to future demand in an effective and efficient manner. The aims of this report are as follows:

- **Aim 1:** Identify publicly funded SUD and mental health MH services offered in Florida by funder/program and population.
- **Aim 2:** Map workforce availability, provider gaps, and service needs by region.
- **Aim 3a:** Assess the cost management strategies of publicly funded SUD/MH services in Florida.
- **Aim 3b:** Compare SUD/MH service costs in Florida to national and regional SUD/MH service costs.
- **Aim 4:** Provide evidence-based, policy-relevant recommendations to 1) reduce service gaps, 2) improve quality of care and cost management strategies, and 3) increase provider availability by service/region need.

Chapter 2: Identifying Publicly Funded Substance Use and Mental Health Services in Florida

Overview

Florida's publicly funded behavioral health services include those funded by the federal government, the State, and local counties or cities. Federal funding comes through the Medicaid program, lump sum block grants, and other federal grants. State funding is primarily from general revenue, though, in recent years, settlement funds from opioid litigation have been added into the budget. Funding can either be recurring or time-limited (non-recurring), and it can also be restricted for use with specific populations (e.g., children) and /or services (e.g., crisis). Some

individual County and city governments also provide varying amounts of additional indigent care funding for behavioral health that may include services provided to people who are incarcerated. Last, all Florida counties participate in the Statewide Health Care Responsibility Act (HCRA) which legally obligates each county to cover costs for qualified indigent residents receiving emergency care outside the county.

As previously described in the introduction, Florida's largest share of funds for behavioral health services are appropriated to two main funders: 1) Agency for Health Care Administration who administers the state's Medicaid program, and 2) Florida Department of Children and Families Office of Substance Abuse and Mental Health (SAMH)[27]. SAMH contracts with seven Managing Entities statewide to manage the delivery of community-based behavioral health services through a network of local service providers. MEs do not receive funding for MH or SUD institutional care services.

Other state agencies who fund behavioral health services in Florida include the State's Departments of Corrections, Juvenile Justice, Education, and Veteran Affairs. Services funded by these agencies are typically delivered within each agency's respective settings. For instance, most DOE-funded services are delivered in school settings, and DOC-funded services are typically provided in correctional settings.

County and local governments throughout Florida also provide varying levels of healthcare support for uninsured and low-income residents through county-funded healthcare programs, indigent care initiatives, and alternative coverage arrangements. Services available through these local programs vary by jurisdiction and may include primary care, specialty care, prescription assistance, care coordination, and behavioral health services. This coverage is enabled in some counties through the state's Health Flex Plan Program through Section 408.909,

F.S, which became effective July 1, 2002. The Health Flex program expands healthcare options for low-income uninsured residents by encouraging insurers, health maintenance organizations, local governments, healthcare districts, and community organizations to develop alternatives to traditional insurance models emphasizing basic and preventive healthcare services. Currently, Health Flex services are available through American Care, Inc. in Broward, Hillsborough, Miami-Dade, Palm Beach, Polk, and St. Lucie Counties[42].

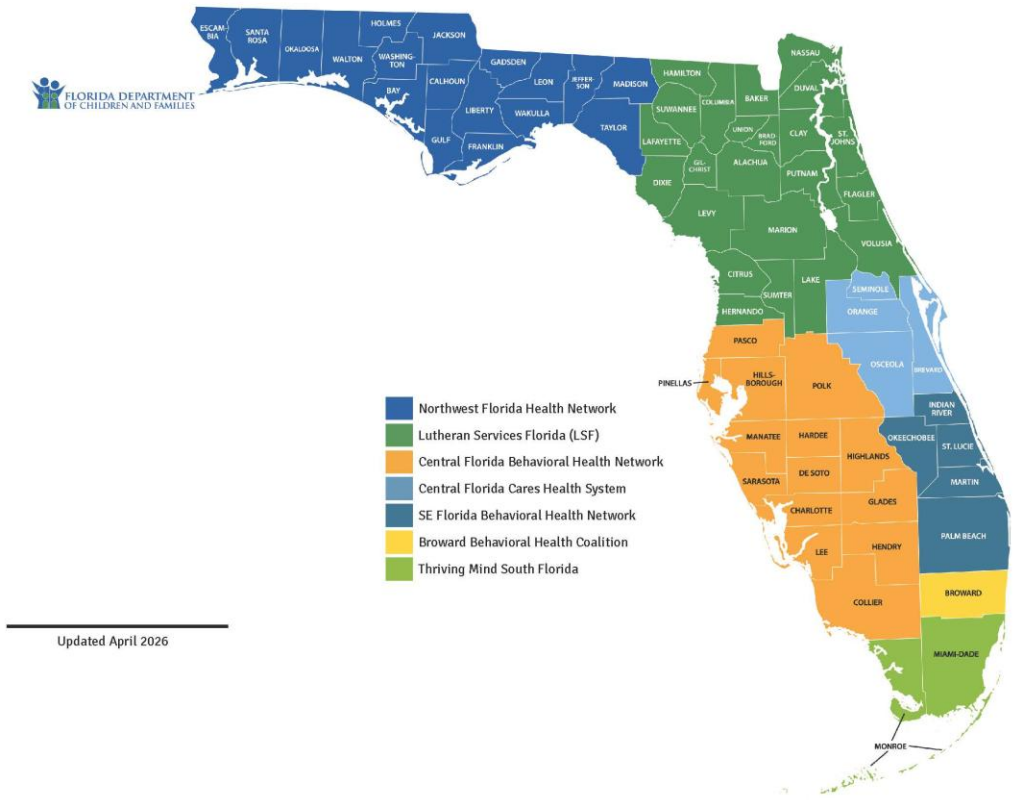
Examples of local healthcare coverage approaches enabled through Health Flex include the Hillsborough County Health Plan and Polk HealthCare Plan. Hillsborough County Health Plan members may receive behavioral health services coordinated through their primary care providers, with access to additional mental and behavioral health services when medically necessary. Similarly, Polk HealthCare Plan partners with physicians, clinics, and hospitals to provide primary care, specialty care, and behavioral health services for eligible residents. Although program summaries do not consistently specify all covered behavioral health modalities, available services generally include behavioral health assessments, counseling and therapy services, referral mechanisms, prescription services, and care coordination through primary care settings.

DCF ME Services

DCF contracts with seven MEs (see Figure 1). Behavioral health services are categorized across a set of "core services" that are classified into four core program areas: adult mental health (AMH), adult substance abuse (ASA), child mental health (CMH), and child substance abuse (CSA). Per DCF definitions, adults are defined as individuals 18 and older, whereas children are defined as individuals younger than 18 years old. DCF publishes an annual Catalog

of Care that identifies which covered core services are provided in each program area by each ME. DCF's latest available Catalog of Care based on services provided in FY24/25 (DCF, 2026) was used to identify DCF's covered services[43].

Figure 1. Florida Managing Entity Map



Note. Adapted from https://www.myflfamilies.com/documents/FLME%20Contact%20List.pdf

A summary of adult and child services offered across the seven MEs contracted through DCF are provided in Table 2, while Table 3 states the number of different community-based services that were funded by DCF in FY24/25 within each of the four core and three other program areas. As noted in the table, many core program area behavioral health services were covered in FY24/25, including 56 different adult mental health services, 43 different adult

substance abuse services, 40 different child mental health services, and 56 different child substance abuse services.

Table 2. Summary of ME Services

DCF Community-Based Services	Florida Department of Children and Families (DCF) Managing Entity (ME) Regions							
Service	**BBHC**	**CFBHN**	**CFCHS**	**LSF**	**NFHN**	**SFBHN**	**SEFBHN**	**Non-ME**
Aftercare	A/C	A	A	A	A	A	A	-
Alternatives to Incarceration Pasco - Jail Reentry	-	-	-	-	-	-	-	A
Assessment	A/C	A/C	A/C	A/C	A/C	A/C	A/C	-
Behavioral Health Network (BNET)	C	C	C	C	C	C	C	-
Bob Janes Triage Center / Low Demand Shelter	-	-	-	-	-	-	-	A
Brevard Adult Mobile Crisis Co-Responder Team	-	-	A/C	-	-	-	-	A
Care Coordination	A/C	A/C	A/C	A/C	A/C	A	A/C	-
Case Management	A/C	A/C	A/C	A/C	A/C	A/C	A/C	-
Central Receiving System	A	-	A/C	A	C	A	A	-
CJMSAG Reinvestment Grant	-	-	A	-	-	-	-	A
CJMHSA Enhancements Implementation Project	-	-	-	-	-	-	-	A/C
Collier Criminal Justice MAT Program (CMAT TEAM)	-	-	-	-	-	-	-	A
Community Action Team (CAT Team)	C	C	C	C	C	C	C	-
Complex Case Reintegration Program	-	-	-	-	-	-	-	A
Comprehensive Community Service Team (CCST)	-	-	-	-	-	A/C	A/C	A
Criminal Justice Intensive Case Management Team	-	-	-	-	-	-	-	A
Crisis Stabilization	A/C	A/C	A/C	A/C	A/C	A/C	A/C	-
Crisis Support/Emergency	A/C	A/C	A/C	A/C	A/C	A/C	A/C	-

DCF Community-Based Services	Florida Department of Children and Families (DCF) Managing Entity (ME) Regions							
Service	**BBHC**	**CFBHN**	**CFCHS**	**LSF**	**NFHN**	**SFBHN**	**SEFBHN**	**Non-ME**
CTC-Manatee Comprehensive Treatment Court	-	-	-	-	-	-	-	A
Day Care	C	A	-	A	-	-	-	-
Day Treatment	A/C	A	A	A/C	A	A	A	-
Disaster Behavioral Health	A/C	A/C	A/C	A/C	A/C	A/C	A/C	-
Dixie Mental Health Services Project	-	-	-	-	-	-	-	A/C
Drop In/Self-Help Centers	A	A	A	A	A	A	A	-
Duval County CJRG Expansion	-	-	-	-	-	-	-	C
Family Intensive Treatment Team (FIT Team)	A	A	A	A	A/C	A	A	-
Federal Project Grant	A	-	A	-	A/C	A	A	-
First Episode Team	-	A/C	A/C	A	A/C	A	A	-
First Responder Central Regional Supports - Information and Referral	-	-	-	-	-	-	-	A/C
First Responder Central Regional Supports - Peer-Based Navigation	-	-	-	-	-	-	-	A/C
First Responder Central Regional Supports - Public Awareness Campaign	-	-	-	-	-	-	-	A/C
First Responder Northeast Regional Supports - Behavioral Health Services	-	-	-	-	-	-	-	A/C
First Responder Northeast Regional Supports - Information and Referral	-	-	-	-	-	-	-	A/C
First Responder Northeast Regional Supports - Peer-Based Navigation	-	-	-	-	-	-	-	A/C
First Responder Northeast Regional Supports - Public Awareness Campaign	-	-	-	-	-	-	-	A/C
First Responder Southeast Regional Supports - Information and Referral	-	-	-	-	-	-	-	A/C
First Responder Southeast Regional Supports - Peer-Based Navigation	-	-	-	-	-	-	-	A/C
First Responder Southeast Regional Supports - Public Awareness Campaign	-	-	-	-	-	-	-	A/C

DCF Community-Based Services	Florida Department of Children and Families (DCF) Managing Entity (ME) Regions							
Service	**BBHC**	**CFBHN**	**CFCHS**	**LSF**	**NFHN**	**SFBHN**	**SEFBHN**	**Non-ME**
First Responder Statewide Toolkit	-	-	-	-	-	-	-	A/C
First Responder SunCoast Regional Supports - Information and Referral	-	-	-	-	-	-	-	A/C
First Responder SunCoast Regional Supports - Peer-Based Navigation	-	-	-	-	-	-	-	A/C
First Responder SunCoast Regional Supports - Public Awareness Campaign	-	-	-	-	-	-	-	A/C
Flagler Youth and Young Adult Diversion Expansion Program	-	-	-	-	-	-	-	A/C
Florida Assertive Community Treatment Team (FACT Team)	A	A	A	A	A	A	A	-
Florida's Coordinated Opioid Recovery (CORE) Network of Addiction Care	A	-	A	A	-	-	-	-
Forensic Community Services Team	-	-	-	-	-	-	-	A
Forensic Local Diversion Project	A	-	-	-	-	-	-	-
Forensic Multidisciplinary Team	A	A	A	A	A	A	A	-
Gadsden County Criminal Justice Diversion Project	-	-	-	-	-	-	-	A
HIV Early Intervention Services	A/C	A	A/C	-	-	A	A/C	-
Helping Achieve Targeted Comprehensive Healthcare	-	-	-	-	-	-	-	A
Hendry and Glades Mental Health Services Project	-	-	-	-	-	-	-	A/C
Hillsborough County Juvenile Justice Mental Health Court Expansion	-	-	-	-	-	-	-	C
Hillsborough Forensic ImpACT Team Expansion (H-FITE)	-	-	-	-	-	-	-	A
Incidental Expenses	A/C	A/C	A/C	A/C	A	A/C	A/C	A
Indian River County MH Court Wraparound Project	-	-	-	-	-	-	-	A
In-Home and On-Site	A/C	A/C	A/C	A/C	A	A/C	A/C	-
Juvenile Incompetent to Proceed (JITP) Program - Case Management	-	-	-	-	-	-	-	C

DCF Community-Based Services	Florida Department of Children and Families (DCF) Managing Entity (ME) Regions							
Service	**BBHC**	**CFBHN**	**CFCHS**	**LSF**	**NFHN**	**SFBHN**	**SEFBHN**	**Non-ME**
Juvenile Incompetent to Proceed (JITP) Program - Competency Evaluation	-	-	-	-	-	-	-	C
Juvenile Incompetent to Proceed (JITP) Program - Competency Training	-	-	-	-	-	-	-	C
Juvenile Incompetent to Proceed (JITP) Program - Secure Residential	-	-	-	-	-	-	-	C
Levy County CJMHSAG Implementation and Expansion	-	-	-	-	-	-	-	A
Local Forensic Diversion Project	-	-	-	A	-	-	-	-
MYFLVET Helpline, Care Coordination Services	-	-	-	-	-	-	-	A
MYFLVET Helpline, System Expansion Services	-	-	-	-	-	-	-	A
Martin County - Implementation & Expansion of MH Services	-	-	-	-	-	-	-	A
Medical Services	A/C	A/C	A/C	A/C	A/C	A/C	A/C	A
Medication Assisted Treatment	A	A	A	A	A	A	A	-
Mental Health Clubhouse Services	A	A	A	A	-	A	A	-
Mobile Buprenorphine Clinic	-	-	A	-	-	-	-	A
Multidisciplinary Child Welfare Teams	-	A/C	A	-	-	-	-	-
Network Evaluation & Development	A/C	A/C	A/C	A	A	A/C	A/C	-
Okeechobee Specialty Courts	-	-	-	-	-	-	-	A/C
Opioid Settlement - Non-Qualified County (NQC)	-	-	-	A/C	-	-	-	-
Orange County: Pre-Booking Diversion Drop-In Centers	-	-	-	-	-	-	-	A
Osceola County Emerge Program	-	-	A	-	-	-	-	A
Other Bundled Projects	A/C	A/C	A/C	A/C	A/C	A/C	A/C	-
Other Bundled Projects (Transitional Beds for MH Institution)	-	-	-	A	-	-	-	-

DCF Community-Based Services	Florida Department of Children and Families (DCF) Managing Entity (ME) Regions							
Service	**BBHC**	**CFBHN**	**CFCHS**	**LSF**	**NFHN**	**SFBHN**	**SEFBHN**	**Non-ME**
Other Multidisciplinary Team	A/C	-	-	A	-	-	-	-
Outpatient	A/C	A/C	A/C	A/C	A/C	A/C	A/C	-
Outreach	A/C	A/C	A/C	A/C	A/C	A/C	A/C	-
Pinellas Road to Success Public Defender Project	-	-	-	-	-	-	-	A/C
Prevention - Indicated	A/C	A/C	A/C	A/C	A/C	A/C	A/C	-
Prevention - Selective	A/C	A/C	A/C	A/C	A/C	A/C	-	-
Prevention - Universal Direct	A/C	A/C	A/C	A/C	A/C	A/C	A/C	-
Prevention - Universal Indirect	A/C	A/C	A/C	A/C	A	A/C	A/C	-
Provider Proviso Projects	A/C	A/C	A	A/C	A/C	-A/C	A/C	-
Putnam Crisis Triage and Treatment Unit	-	-	-	-	-	-	-	A/C
Recovery Support	A/C	A/C	A	A/C	A	A/C	A/C	-
Residential Level I	A/C	A/C	A/C	A	-	A/C	A	-
Residential Level II	A/C	A/C	A/C	A/C	A	A/C	A/C	-
Residential Level III	A	A	A	-	A	A	A	-
Residential Level IV	A	A/C	A	A	A	A	A	-
Respite Services	A/C	-	A	A	-	-	A/C	-
Room and Board with Supervision Level I	A	-	C	-	-	-	-	-
Room and Board with Supervision Level II	A	A	A/C	A/C	A	A	A/C	-
Room and Board with Supervision Level III	A	A	A	A	A	A	A	-
Room and Board with Supervision Level IV	A	-	-	A	-	-	-	-

DCF Community-Based Services	Florida Department of Children and Families (DCF) Managing Entity (ME) Regions							
Service	**BBHC**	**CFBHN**	**CFCHS**	**LSF**	**NFHN**	**SFBHN**	**SEFBHN**	**Non-ME**
SOR GPRA Assessment	-	-	-	-	-	-	-	A
Sarasota Comprehensive Treatment Court Expansion	-	-	-	-	-	-	-	A
Self- Directed Care	-	A	-	-	-	-	-	-
Short-term Residential Treatment	A/C	A	A	-	A	A/C	A	A
St. Johns County Jail-Based EPIC Transition Program	-	-	-	-	-	-	-	A
Start-Up Cost Reimbursement	A/C	A/C	A/C	-	A/C	A/C	A/C	-
Substance Abuse Inpatient Detoxification	A	A/C	A/C	A	A	A/C	A	-
Substance Abuse Outpatient Detoxification	A	-	A	-	-	-	-	-
Supported Employment	A/C	A	-	A	A	A	A	-
Supportive Housing/Living	A/C	A	A	A	A	A	A/C	-
The Village of Care Leon County	-	-	-	-	-	-	-	C
Treatment Alternative for Safer Communities (TASC)	-	-	A/C	C	A/C	C	A/C	-
VIVITROL Assessment, Including Physical Examination and Lab Work	-	-	-	-	-	-	-	A
VIVITROL Distribution - Subcontracted Management Services	-	-	-	-	-	-	-	A
VIVITROL Medication Management, Medication Administration, Lab Work, and Medication.	-	-	-	-	-	-	-	A
VIVITROL Screening and Medication Education	-	-	-	-	-	-	-	A
Wraparound and Intervention Strategies	-	-	-	-	-	-	-	C
Youth Criminal Justice Diversion Initiative	-	-	-	-	-	-	-	C

Note: Data were pulled from DCF's FY24/25 Catalog of Care. Adults = A; Child = C.

Table 3. Number of Different Types of Behavioral Health Services Covered by DCF in 24/25 by Program Area

	Number of Different Types of Services Funded in Program Area	Report Table That Identifies These Services
Core Program Areas		
Adult Mental Health	56	Appendix Table 1
Adult Substance Abuse	43	Appendix Table 2
Child Mental Health	40	Appendix. Table 3
Child Substance Abuse	56	Appendix. Table 4

The appendix contains additional tables that specify the different FY24/25 DCF-funded services provided by each ME within each of the four core program areas, including adult mental health services (AMH; Appendix Table 1, adult substance abuse services (ASA; Appendix Table 2, child mental health services (CMH; Appendix Table 3), and child substance abuse services (CSA; Appendix Table 4).

AHCA Service Array

Florida Medicaid (AHCA), the primary payor of publicly funded behavioral health services, publishes fee schedules across a variety of service types and settings, including but not limited to applied behavioral analysis (ABA), community-based behavioral health services, mental health targeted case management, specialized therapeutic services, and school county match programs. Given the scope of this report and overlap between procedure codes, descriptions, and populations, the most recently published fee schedules for Medicaid behavioral health services were compiled to identify the array of services offered, and can be found in Appendix Table 5[44,45,46,47,48,49,50,51]. Additional services referenced in Medicaid coverage policy handbooks were not included.

Chapter 3: Map Workforce Availability, Provider Gaps, and Service Needs

Overview

A combined geospatial and supply and demand modeling approach was used to assess behavioral health service availability, workforce capacity, and population-level demand across Florida. Geospatial analyses identified geographic patterns in behavioral health provider locations and visually assessed potential service gaps using point-based spatial representation. County-level workforce supply and demand were separately analyzed using licensure data from the Florida Department of Health and multiple population-based indicators, including Behavioral Risk Factor Surveillance System (BRFSS) measures, Baker Act data, and population estimates. Workforce supply was estimated across six behavioral health professions over time and demand was modeled dynamically using a composite behavioral health risk indicator.

Data Collection and Analysis

Provider location data were compiled from multiple publicly available and administrative sources between January 2026 and May 2026. Medicare and Medicaid-funded behavioral health treatment provider locations were obtained from the Substance Abuse and Mental Health Services Administration Treatment Locator[52]. Managing entity provider location data were obtained directly from each Florida managing entity via email request coordinated with assistance from the Florida Association of Managing Entities (FAME) to ensure completeness and standardization across regions. Medicare-, Medicaid-, and ME-funded data represented the most recent provider listings at the time of extraction and included both adult and child-serving substance use and mental health treatment providers. Behavioral health provider locations were mapped across Florida to better understand where services are available and identify areas with

higher or lower concentrations of providers. Each provider location was displayed as a point on the map, allowing for visualization of service distribution, geographic clustering, and potential gaps in access to care across different regions of the state. ArcGIS and Excel were used to create dot-density and choropleth maps. Detailed information on the data collection and analysis process is provided in the Appendix.

Workforce supply projections with population-based estimates of service demand across Florida counties focused on six core behavioral health professions: Licensed Clinical Social Workers (LCSWs), Licensed Mental Health Counselors (LMHCs), Licensed Marriage and Family Therapists (LMFTs), Clinical Psychologists, Psychiatrists, and Psychiatric Mental Health Nurse Practitioners (PMHNPs). The Florida Department of Health licensure database provided the workforce data used in the analysis[53]. The demand estimates incorporated multiple population-level indicators of behavioral health need. The analysis used BRFSS indicators of mental health, substance use, and barriers to treatment, along with Baker Act examination data, population estimates from the Florida Office of Economic and Demographic Research, and U.S. Census demographic projections[54,55,56]. Initial benchmark provider-to-population ratios anchored the demand estimates in 2017, but demand modelling combined Behavioral Risk Factor Surveillance System (BRFSS) indicators, Baker Act examinations, suicide rates, and drug overdose data into a behavioral health risk variable allowing projected workforce demand to respond to changes in behavioral health conditions across Florida communities. For details including data preparation and technical spatial analysis and supply and demand modelling information, see Appendix Narrative 1.

Results

Geospatial Distribution of Providers

Figure 2 illustrates the spatial distribution of publicly funded behavioral health service providers across Florida using a dot density map of deduplicated provider locations. The distribution shows that provider sites do not occur uniformly across the state. Instead, providers concentrate in specific geographic areas, while large portions of Florida exhibit comparatively sparse coverage. Clear clustering of provider locations occurs within major metropolitan regions, particularly along the eastern and western coasts. High densities of provider locations appear in the Jacksonville area, Orlando metropolitan region, Tampa Bay region, and the Miami–Fort Lauderdale corridor).

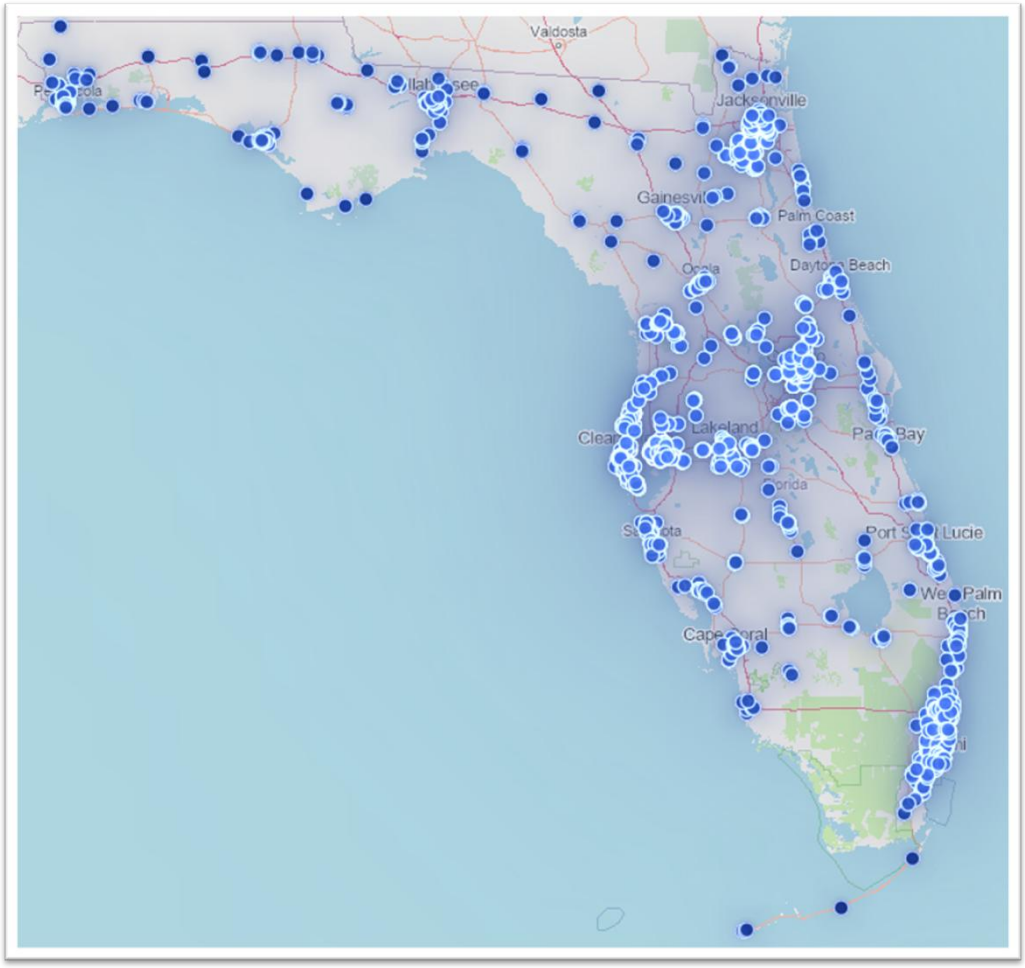
These metropolitan areas contain dense groupings of provider locations, which indicates that behavioral health services largely align with urban population centers. In several metropolitan regions, providers form tightly clustered patterns. In contrast, rural and interior portions of Florida exhibit substantially lower provider density, particularly within northern inland counties and portions of south-central Florida. These patterns indicate the presence of service gaps or limited local access, where residents likely must travel greater distances to obtain behavioral health services.

The spatial distribution also reveals clear regional variation across Florida and reflects broader patterns of population concentration and development. In the Panhandle region, providers appear across the region but cluster primarily along coastal areas and major transportation corridors, while inland locations remain more sparsely served. North Central Florida shows comparatively limited coverage overall, with only small, isolated clusters located near mid-sized cities. Central Florida demonstrates moderate to high provider density, with multiple clusters forming around major metropolitan hubs and extending into surrounding

suburban areas. South Florida exhibits the highest level of concentration, with dense and continuous clustering along the southeastern corridor.

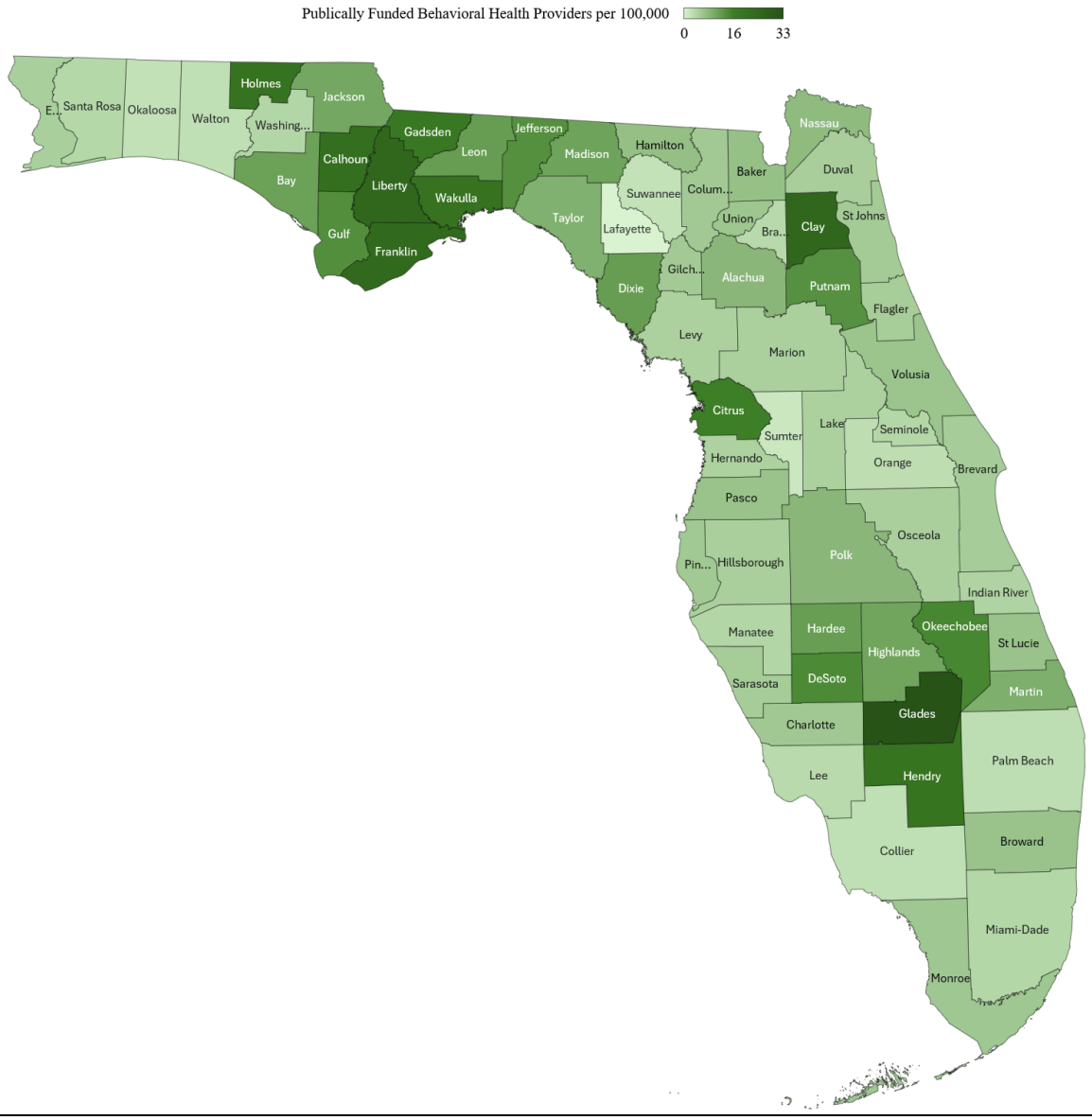
Overall, provider service locations mirror patterns of population density and urban development, with the greatest concentration of providers occurring in densely populated areas. The dot distribution further demonstrates pronounced spatial clustering rather than a random or even dispersion of providers across the state. Providers consistently locate near major road networks and urban centers and frequently co-locate in proximity to other providers, which reflects the concentration of services in areas with established infrastructure and higher demand. At the same time, geographically isolated and less densely populated areas contain relatively few provider locations. These spatial patterns reinforce the alignment between publicly funded behavioral health service availability and population density, though telehealth utilization was unable to be captured and may or may not fill in gaps.

Figure 2. Publicly Funded Behavioral Health Providers



Note. This dot density map displays deduplicated behavioral health provider locations across Florida. When provider locations are clustered more densely, the blue dots appear illuminated (e.g., extent of white outline). The dataset integrates publicly available Medicare- and Medicaid-funded provider records from the SAMHSA Treatment Locator with managing entity (ME) provider location data obtained directly from Florida managing entities. The final analytic dataset includes both adult and child-serving mental health and substance use treatment providers. Duplicate provider records across sources were identified and removed prior to mapping to ensure each provider location is represented once.

Figure 3. Publicly Funded Behavioral Health Provider Sites per 100,000 Population by County in Florida



Note. This choropleth map displays the number of publicly funded behavioral health provider sites per 100,000 population at the county level across Florida. Provider site counts reflect deduplicated locations compiled from managing entity (ME) data and publicly available Medicare- and Medicaid-funded provider records from the SAMHSA Treatment Locator. Duplicate entries across data sources were identified and removed to ensure each site is represented once. Records associated with P.O. boxes or incomplete addresses were excluded prior to analysis. County population estimates were obtained from the American Community Survey (ACS) and used to calculate standardized site-to-population ratios. Darker shading indicates a higher number of provider sites per 100,000 residents, while lighter shading indicates lower relative site density. These values reflect the distribution of provider locations relative to population and do not indicate service capacity, utilization, or availability at individual sites. Due to size limitations, some county names were abbreviated.

The dot density map (Figure 2) illustrates the absolute distribution of provider locations, while the choropleth map (Figure 3) depicts provider availability normalized per 100,000 population. The dot density map reveals that provider locations are unevenly distributed across the state and exhibit pronounced spatial clustering where high concentrations of providers occur within major metropolitan areas while low concentrations of providers occur in less urbanized areas. The population-adjusted choropleth map (Figure 3) provides a different, though complementary, perspective. When provider counts are standardized by population, several less densely populated counties exhibit moderate to relatively high provider-to-population ratios despite having few absolute provider locations. In contrast, many highly populated urban counties, which appear densely clustered in the dot density map, show more moderate per capita rates. This divergence reflects differences between absolute supply (number and location of providers) and relative supply (providers per population).

Urban areas show high concentrations of providers but also have substantially larger populations, which reduces their provider-to-population ratios. Conversely, some rural counties contain relatively few providers but also serve much smaller populations, resulting in comparable or higher per capita rates. As a result, areas that appear underserved in the dot density map due to sparse provider presence may not be truly underserved as noted in the population-adjusted map. Importantly, these findings do not represent a contradiction but instead highlight distinct dimensions of access. The dot density map captures the geographic availability and spatial distribution of providers, while the per-100,000 choropleth map reflects population-adjusted service capacity. When interpreted together, the maps reveal that geographic accessibility and population-based adequacy do not consistently align across regions. A table

with county-level provider counts and density per 100,000 people can be found in Appendix Table 6.

211 Call Center

The 211 call center data (see Table 4) provide further insight into the spatial distribution and intensity of behavioral health demand across Florida[57]. These data identify where behavioral health–related needs are most prevalent, as reflected by both the volume of requests and the proportion of calls involving mental health or substance use concerns. In addition to capturing overall demand, variation in the percentage of needs related to behavioral health highlights differences in the intensity of need across service regions. This indicates where behavioral health systems may experience greater pressure, as regions with high volumes of behavioral health requests and elevated proportions of need likely face increased demand relative to available resources.

Table 4. Florida 211 Call Centers

211 Call Centers[1]	Accredited[1]	Answer 988 Calls[1,2]	Counties Served[1]	# Counties	# of Calls[3]	# of Needs	% Needing Mental Health/Addiction[4]
Crisis Center of Tampa Bay	YES	YES	Hillsborough	1	96,905	290,753	47.30%
211 Big Bend	YES	YES	Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, & Wakulla,	8	19,128	25,233	9.00%
211 Brevard	YES	YES	Brevard, Flager, & Volusia	3	58,450	97,138	23.20%
211 Broward	YES	YES	Broward	1	56,076	127,581	24.70%
211 Heart of Florida United Way[5]	YES	YES	Alachua, Bradford, Citris, Collier, Desoto, Dixie, Hardee, Gilchrist, Highlands, Lake, Levy, Manatee, Orange, Oseola, Polk, Sarasota, Seminole, Sumter, & Union	19	201,022	276,410	7.20%

211 Call Centers[1]	Accredited[1]	Answer 988 Calls[1,2]	Counties Served[1]	# Counties	# of Calls[3]	# of Needs	% Needing Mental Health/Addiction[4]
211 Miami-Dade	YES		Miami-Dade, Monroe	2	100,485	125,441	28.10%
211 Palm Beach & Treasure Coast	YES	YES	Indian River, Martin, Okeechobee, Palm Beach, & St Lucie	5	129,149	176,557	30.80%
211 Tampa Bay Cares (now known as First Contact)	YES	YES	Pinellas & Hernando	2	52,430	98,751	6.00%
United Way of Lee, Hendry, & Glades	YES	YES	Charlotte, Lee, Hendry, & Glades	4	23,841	36,683	2.90%
United Way of Northwest Florida 211	YES	YES	Baker, Clay, Columbia, Duval, Hamilton, Laffayette, Nassau, Putnam, St Johns, & Suwanne	10	71,561	47,398	9.10%
United Way of West Florida	YES	YES	Bay, Calhoun, Escambia, Gulf, Holmes, Jackson, Okaloosa, Santa Rosa, Walton, & Washington	10	23,371	N/A	N/A
No 211 coverage at this point in time			Marion & Pasco	2			
			Overall	67	832,418	1,301,945	20.20%

Sources and Notes

[1]Florida 211 (fl211.org) and verified/updated with personal communication from the Crisis Center of Tampa Bay

[2]Counties served by 211 call centers do not perfectly align with counties served by 988

[3]211 Counts website **https://211counts.org** Data reported are from April 16, 2025 - April 15, 2026

[4]Hearts of Florida United Way website **https://hfuw.org** Data reported are from January 1, 2024-January 31, 2026 Calls and needs were divided in half to obtain a 1 year estimate similar to the other call centers

[5]Number of calls and needs obtained from 211 Heart of Florida website; percentage of needs that are mental health and/or additions from 211counts website

[6]Data on number of calls obtained from the 2024 United Way West Florida annual report; mental health was noted a top request https://heyzine.com/flip-book/0eb9fbb105.html#page6

Supply and Demand

Supply was operationalized as the number of licensed behavioral health professionals, while demand was a combination of various factors that contribute to a demand for behavioral health providers (including BRFSS data, Baker Act, suicide, and drug overdose data). Demand as a function of behavioral health provides a more nuanced view of what contributes to a demand for behavioral health beyond traditional per capita guidelines for behavioral health providers. The results demonstrated substantial geographic disparities in workforce supply and workforce adequacy across Florida counties. Table 5 showed that many counties failed to meet projected demand across multiple professions, particularly for psychiatrists, PMHNPs, and psychologists. Consistent with geospatial results, urban counties generally maintained larger behavioral health workforces, but several still fell below projected demand levels despite employing substantial numbers of providers. Broward County, for example, employed 169 psychiatrists but met only 59% of projected psychiatrist demand. Duval County similarly met only 61% of psychiatrist demand and 59% of PMHNP demand despite maintaining one of the larger behavioral health workforces in the state. Miami-Dade displayed some of the largest shortages overall, particularly for psychiatrists, psychologists, and PMHNPs, indicating that workforce growth has not kept pace with population growth and behavioral health need in the state's largest metropolitan area.

Several counties either met or exceeded projected workforce demand across multiple professions. Hillsborough County nearly achieved full workforce coverage for most professions and exceeded projected demand for psychologists and psychiatrists. Pinellas County exceeded projected demand for nearly every profession included in the analysis, including psychologists, LMHCs, and LCSWs. Leon County substantially exceeded projected demand for LCSWs, LMFTs, and psychologists, while Sarasota and Seminole counties also exceeded projected

demand across several provider categories. These findings suggest that some counties have developed comparatively strong behavioral health infrastructures capable of supporting local demand.

Substantial rural workforce shortages were seen throughout the state. Smaller and more rural counties frequently reported very low workforce coverage or complete provider absence for specific professions. Counties such as Lafayette, Glades, Hendry, Union, and Taylor reported no psychiatrists despite measurable projected demand for psychiatric services. Many rural counties also lacked psychologists and LMFTs entirely. Baker County, for example, met only 20% of projected psychiatrist demand and reported no psychologists or LMFTs. Dixie County similarly had no psychiatrists or PMHNPs and met less than 25% of projected demand across several provider categories. These findings indicate that many rural shortages reflect not only insufficient provider supply, but also persistent structural barriers to establishing workforce infrastructure in underserved regions.

Psychiatry emerged as one of the most constrained workforce areas statewide. Even counties with relatively strong behavioral health workforces often struggled to meet projected psychiatrist demand. Lee County met only 48% of projected psychiatrist demand, Volusia met 35%, Pasco met 40%, and Osceola met only 19%. Multiple counties reported no psychiatrists at all. These findings suggest that psychiatry remains one of the largest bottlenecks within Florida's behavioral health workforce system.

PMHNPs showed stronger workforce penetration than psychiatrists in several areas, but shortages remained widespread. Larger counties such as Hillsborough, Palm Beach, and Sarasota met much of their projected PMHNP demand, while many rural counties continued to report extremely limited PMHNP availability. Some counties, including Jackson and Madison,

demonstrated relatively high PMHNP coverage despite shortages in other professions, potentially reflecting increasing reliance on advanced nursing roles in underserved areas.

LCSWs and LMHCs generally demonstrated the strongest workforce supply statewide. Several counties exceeded projected demand for these professions, including Alachua, Leon, Sarasota, Seminole, and Santa Rosa. However, shortages remained evident in many rapidly growing metropolitan areas and rural counties. Miami-Dade, Polk, Osceola, and Volusia all fell below projected demand for both LCSWs and LMHCs, suggesting that provider growth has not fully kept pace with behavioral health need in several high-growth regions.

The provider-per-capita estimates further illustrated substantial geographic inequities in behavioral health workforce distribution. Counties containing major universities, urban service centers, or large healthcare systems generally maintained the highest provider densities. Alachua, Leon, Palm Beach, Pinellas, and Seminole counties reported some of the highest total behavioral health provider rates per 100,000 residents across all six professions combined. In contrast, many rural counties maintained fewer than 100 total providers per 100,000 residents. Taylor, Hendry, Lafayette, and Union counties showed especially low workforce densities, reinforcing the broader pattern of rural workforce scarcity throughout the state.

Overall, the findings demonstrated that Florida's behavioral health workforce remains highly uneven across both geography and profession. Urban counties generally maintained stronger provider infrastructures, although many still failed to meet projected demand for psychiatrists, PMHNPs, and psychologists. Rural counties experienced the most severe shortages, with many lacking entire categories of behavioral health providers. The results suggest that workforce planning efforts will need to address both overall workforce growth and the continued geographic concentration of behavioral health services across Florida communities.

Given provider shortages in rural and less populated areas, future state investments may want to support co-location or satellite programs that enable existing provider reach in under resourced counties and regions.

Table 5. Supply and Demand of Behavioral Health Providers by County

County	Licensed Clinical Social Workers			Licensed Mental Health Counselors			Licensed Marriage and Family Therapists			Clinical Psychologists			Psychiatric Mental Health Nurse Practitioners			Psychiatrists		
	Supply	Demand	% Met	Supply	Demand	% Met	Supply	Demand	% Met	Supply	Demand	% Met	Supply	Demand	% Met	Supply	Demand	% Met
Alachua	318	223	143	340	275	124	71	52	137	214	91	235	97	106	92	76	40	190
Baker	3	25	12	17	31	55	0	6	0	0	11	0	5	12	42	1	5	20
Bay	101	132	77	142	134	106	13	23	57	11	46	24	53	54	98	13	16	81
Bradford	7	24	29	13	29	45	0	6	0	2	10	20	1	12	8	1	5	20
Brevard	391	334	117	449	500	90	47	74	64	150	109	138	86	177	49	34	46	74
Broward	1476	1900	78	1535	1869	82	500	516	97	755	868	87	653	788	83	169	285	59
Calhoun	2	11	18	5	11	45	0	2	0	1	4	25	0	5	0	0	2	0
Charlotte	86	117	74	114	120	95	6	18	33	19	49	39	23	48	48	12	20	60
Citrus	68	87	78	62	131	47	7	20	35	8	29	28	12	46	26	3	12	25
Clay	128	196	65	168	242	69	21	46	46	27	80	34	51	93	55	7	35	20
Collier	169	261	65	178	267	67	29	40	72	85	108	79	72	106	68	44	43	102
Columbia	44	61	72	32	75	43	3	14	21	6	25	24	9	29	31	3	11	27
DeSoto	12	23	52	12	24	50	1	4	25	2	10	20	4	10	40	1	4	25
Dixie	3	15	20	3	19	16	1	4	25	1	6	17	0	7	0	0	3	0
Duval	602	793	76	779	979	80	98	183	54	231	323	72	221	375	59	85	140	61
Escambia	211	220	96	253	223	113	22	38	58	57	77	74	57	91	63	34	26	131
Flagler	59	112	53	92	138	67	16	26	62	11	46	24	29	53	55	3	20	15
Franklin	3	9	33	6	9	67	1	2	50	2	3	67	0	4	0	0	1	0
Gadsden	23	35	66	18	36	50	2	6	33	11	13	85	7	15	47	0	5	0
Gilchrist	3	15	20	5	19	26	0	4	0	0	7	0	3	8	38	1	3	33
Glades	3	10	30	0	10	0	0	2	0	1	4	25	0	4	0	0	2	0
Gulf	3	13	23	4	13	31	1	3	33	1	5	20	0	5	0	0	2	0
Hamilton	1	13	8	4	16	25	2	3	67	0	6	0	1	6	17	0	3	0
Hardee	3	16	19	6	24	25	0	4	0	1	6	17	1	9	11	0	3	0

County	Licensed Clinical Social Workers			Licensed Mental Health Counselors			Licensed Marriage and Family Therapists			Clinical Psychologists			Psychiatric Mental Health Nurse Practitioners			Psychiatrists		
	Supply	Demand	% Met	Supply	Demand	% Met	Supply	Demand	% Met	Supply	Demand	% Met	Supply	Demand	% Met	Supply	Demand	% Met
Hendry	7	26	27	7	27	26	0	4	0	0	11	0	1	11	9	0	5	0
Hernando	104	116	90	75	173	43	15	26	58	10	38	26	45	61	74	6	16	38
Highlands	20	61	33	38	91	42	6	14	43	8	20	40	8	32	25	4	9	44
Hillsborough	1041	1015	103	1031	1040	99	147	156	94	487	421	116	350	412	85	177	166	107
Holmes	5	15	33	7	15	47	0	3	0	0	6	0	6	6	100	0	2	0
Indian River	82	160	51	89	158	56	21	44	48	41	73	56	31	67	46	10	24	42
Jackson	17	36	47	34	37	92	1	7	14	9	13	69	26	15	173	0	5	0
Jefferson	8	11	73	8	11	73	0	2	0	2	4	50	3	5	60	0	2	0
Lafayette	1	8	12	0	10	0	0	2	0	0	4	0	0	4	0	0	2	0
Lake	187	214	87	246	321	77	34	48	71	41	70	59	84	114	74	10	30	33
Lee	394	539	73	400	551	73	41	83	49	124	223	56	161	219	74	42	88	48
Leon	356	217	164	189	219	86	66	37	178	168	76	221	65	89	73	26	26	100
Levy	14	37	38	12	45	27	0	9	0	1	15	7	6	18	33	0	7	0
Liberty	2	7	29	5	7	71	0	2	0	2	3	67	2	3	67	0	1	0
Madison	3	16	19	5	20	25	1	4	25	1	7	14	7	8	88	0	3	0
Manatee	252	261	97	244	267	91	31	40	78	97	108	90	77	106	73	24	43	56
Marion	154	220	70	200	331	60	20	49	41	41	72	57	63	117	54	16	31	52
Martin	131	160	82	126	157	80	18	44	41	43	73	59	32	67	48	8	24	33
Miami-Dade	1323	2270	0	1880	2837	0	431	675	0	894	1386	0	712	1422	0	273	541	0
Monroe	36	59	61	38	73	52	10	18	56	8	36	22	15	37	41	2	14	14
Nassau	54	73	74	58	91	64	12	17	71	22	30	73	14	35	40	9	13	69
Okaloosa	142	145	98	163	147	111	19	25	76	33	51	65	39	60	65	9	17	53
Okeechobee	6	41	15	17	41	41	2	12	17	1	19	5	4	17	24	2	7	29
Orange	734	838	88	1347	1257	107	204	185	110	264	272	97	263	443	59	127	116	109
Osceola	128	223	57	193	335	58	28	50	56	37	73	51	71	118	60	6	31	19
Palm Beach	1490	1495	100	1419	1471	96	267	406	66	589	683	86	336	620	54	215	224	96

County	Licensed Clinical Social Workers			Licensed Mental Health Counselors			Licensed Marriage and Family Therapists			Clinical Psychologists			Psychiatric Mental Health Nurse Practitioners			Psychiatrists		
	Supply	Demand	% Met	Supply	Demand	% Met	Supply	Demand	% Met	Supply	Demand	% Met	Supply	Demand	% Met	Supply	Demand	% Met
Pasco	376	380	99	387	389	99	38	59	64	114	158	72	119	155	77	25	63	40
Pinellas	825	620	133	825	635	130	125	95	132	323	257	126	226	252	90	100	102	98
Polk	275	408	67	404	612	66	31	90	34	55	133	41	105	216	49	34	57	60
Putnam	12	60	20	18	74	24	6	14	43	4	25	16	2	29	7	0	11	0
St. Johns	210	199	105	221	202	109	27	34	79	30	70	43	78	82	95	13	24	54
St. Lucie	266	346	77	280	340	82	50	94	53	103	158	65	82	144	57	32	52	62
Santa Rosa	160	133	120	148	135	110	15	23	65	28	47	60	47	55	85	12	16	75
Sarasota	347	279	124	382	286	134	49	43	114	136	116	117	83	114	73	41	46	89
Seminole	359	272	132	621	408	152	88	60	147	117	89	131	87	144	60	32	38	84
Sumter	40	89	45	35	133	26	7	20	35	13	29	45	17	47	36	4	13	31
Suwanee	12	40	30	8	50	16	2	10	20	2	17	12	5	19	26	0	8	0
Taylor	2	20	10	2	24	8	1	5	20	1	8	12	1	10	10	0	4	0
Union	2	14	14	3	17	18	0	4	0	1	6	17	0	7	0	0	3	0
Volusia	276	439	63	376	542	69	86	101	85	71	179	40	97	208	47	27	78	35
Wakulla	21	26	81	13	26	50	1	5	20	5	9	56	1	11	9	0	3	0
Walton	30	54	56	51	54	94	13	10	130	9	19	47	8	22	36	10	7	143
Washington	5	19	26	12	20	60	0	4	0	1	7	14	4	8	50	0	3	0

Chapter 4: Assess Cost Management Strategies and Compare Service Costs

Overview

Multiple data sources were used to describe financing, costs, and cost management approaches within Florida's publicly funded behavioral health system. Data from the Florida DCF Catalog of Care were used to characterize contracted service costs across ME and core program areas. State-level investments in service areas were contextualized through national and regional comparisons of behavioral health expenditures, reimbursement rates, and service coverage. In addition, Florida's cost management framework, including the ME model, contracting requirements, and common cost management strategies (e.g., fee-for-service, utilization review, demonstrations etc.) were reviewed. Finally, broader system financing considerations, including Medicaid coverage, resource allocation, and approaches to evaluating return on investment and cost-effectiveness in behavioral health systems were examined.

DCF ME Service Costs

DCF's annual Catalog of Care provides the "total Contracted per service," representing the estimated total amount that each ME has contracted with each provider by service type and area, and was used to identify contracted costs for DCF-funded behavioral health services. The total FY24/25 contracted costs for all DCF-funded behavioral health services across all four core program areas was $987,248,445. Within each of the four program areas, results indicated that the highest total contracted cost was associated with adult mental health (AMH) services that totaled $466,262,564. The second highest total contracted cost was for adult substance abuse (ASA) services at $315,015,543, followed by $146,308,022 for child mental health (CMH) services. The lowest total contracted cost was for child substance abuse (CSA) services that totaled $59,662,316. Table 6 depicts the total FY24/25 amount contracted by DCF to fund all

services within each of the four core program areas broken out by ME. As shown in the table, the same pattern of results emerged for all seven MEs, with the highest total contracted cost associated were associated with adult mental health services, followed by adult substance abuse services, child mental health services, and then child substance abuse services. Appendix Tables 7-10 specify the total estimated cost that DCF contracted in FY24/25 for each different type of community-based service provided by each ME within each of the four core program areas.

Table 6. FY24/25 Total Dollars Contracted by DCF for All Behavioral Health Services in Each Core Program Area by Managing Entity (ME)

Core Program Areas	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	**CFBHN**	**CFCHS**	**LSF**	**NFHN**	**SFBHN**	**SEFBHN**
AMH	$47,417,989	$ 135,399,541	$47,256,835	$101,661,114	$60,527,707	$56,107,093	$51,816,147
ASA	$38,103,370	$118,929,561	$43,712,901	$81,351,077	$28,727,528	$34,964,806	$38,836,989
CMH	$7,459,927	$39,199,048	$13,419,018	$40,195,669	$16,162,171	$10,612,570	$12,827,183
CSA	$4,009,990	$14,525,903	$8,797,996	$13,463,530	$4,611,440	$9,040,520	$7,709,159
Total	**$96,991,276**	**$308,054,054**	**$113,186,75**	**$236,671,391**	**$110,028,846**	**$111,099,319**	**$111,189,478**

Note: Core Program Area AMH is adult mental health; ASA is adult substance abuse; CMH is child mental health; and CSA is child substance abuse. BBHC = Broward Behavioral Health Coalition; CFBHN = Central Florida Behavioral Health Network; CFCHS = Central Florida Cares Health System; LSF = Lutheran Services Florida; NFHS = Northwest Florida Health Network; SFBHN = South Florida Behavioral Health Network; SEFBHN = Southeast Florida Behavioral Health Network

Regional and National Cost Comparisons

Publicly available Medicaid fee schedules for behavioral health services were collected and compared across nine states, including Florida. States were selected based on Mental Health America's state rankings for access to mental health care and prevalence of mental illnesses to represent three high-, mid-, and low-performing states, with Florida categorized as a mid-performing state[15]. Massachusetts, Maine, and Vermont were selected for high-performing, Texas and Alaska for mid-performing, and Alabama, Arizona, and Wyoming for low-performing. Medicaid reimbursements rates by HCPCS and CPT codes were compared across states, where available, as well as the total number of behavioral health services covered by Medicaid FFS.

Using the procedure codes listed in Florida's fee schedules as the reference, each state's fee schedule(s) and/or Medicaid portal was searched for the same codes to identify the comparable rate. The total number of behavioral health services covered was captured through a count of the unique procedure codes included across states' fee schedule(s) and other publicly available state resources.

No procedure codes were universally covered (i.e., covered across all other states examined). Relative to other states, Florida's rate of reimbursement remained consistently lower than most other states, and Florida Medicaid covered a smaller number of services than most other states. Table 7 shows select procedure code rates, which were included if at least one low-, mid-, and high-performing state covered the code. The number of BH services covered, ranged from 30 to 82.

Table 7. Selected State Reimbursement Rate Comparisons Across HCPCS/CPT Codes.

		States								
Description	**HCPCS/ CPT Code**	**FL**	**TX**	**AK**	**AL**	**AZ**	**WY**	**MA**	**ME**	**VT**
		Rates of Reimbursement per Unit Billed (USD- $)								
ABA behavior identification assessment	97151	19.05	24.71*	29.78	25	30.06	19.15	30.73	-	65.8
ABA treatment	97153	12.26	13	22.63	10	17.91	20.5	16.37	-	15
ABA treatment w/ modification	97155	19.17	22.50*	29.78	15	25.05	20.5	30.73	-	49.35
ABA family training	97156	19.05	20.63*	18.69	30	BR (58.66%)	20.5	30.73	-	21.39
Alcohol and/or drug assessment	H0001	15.13	65.27	379.44	-	37.65	-	31.10**	-	-
BH day treatment	H2012	12.6	24.32	47.86	-	15.42	8.47	29.57	26.86*	-

	Total Services[+]	**33**	**71**	**40**	**31**	**58**	**45**	**79**	**30**	**70**

Note: The absence of a rate for a state does not always indicate a lack of coverage for that code. That is, a state may cover a code but on a different time scale or modifier(s), leading to inconsistent comparisons. To be as consistent as possible, codes were selected with the least number of deviations, in addition to the criteria described in the text. **per 15 minutes, as opposed to per assessment (Florida's rate). ABA refers to Applied Behavioral Analysis. BH refers to behavioral health. Not all individuals who receive ABA services have a behavioral health diagnosis.[+] The total number of services were captures by using publicly available fee schedules across states[44,45,46,47,48,49,50,51,58,59,60,61,62,63,64,65,66,67,68,69,70,71,72,73,74,75,76,77,78,79,80,81,82].

These findings align with national examinations in literature. For example, among sixteen commonly used CPT codes surveyed, Florida pays some of the lowest Medicaid Fee for Service (FFS) reimbursement rates in the nation for psychological services when comparing to Medicare, falling below the national average of 74% reimbursement rate[83]. Of a subset of 55 behavioral health services investigated, Florida's median number of services covered through FFS was 30, compared to the national median of 44, suggesting the state covers fewer services than many other states[84].

Additionally, Florida ranks 14th nationally in total State Mental Health Agency (SMHA) expenditures in FY2024 reporting approximately $1.22 billion in expenditures through DCF SAMH, placing it among the higher-spending states in absolute dollars due largely to population size[85]. However, Florida ranked 47th nationally in per capita SMHA expenditures at only $52.34 per resident, far below the national average of $179.36 per capita, suggesting that Florida's behavioral health system is comparatively underfunded relative to population need[85]. Although total expenditures appear substantial, the level of investment spread across Florida's large population results in one of the lowest state mental health spending rates in the nation, including among states that have expanded Medicaid coverage eligibility. This comparatively low per-capita investment may contribute to ongoing system capacity constraints and poorer access to timely, appropriate behavioral health care despite substantial overall spending.

The data reviewed suggests that despite substantial investment, the reach does not meet demand. Florida's expenditure distribution differs substantially from national patterns, with nearly equal investment in state hospital (47.6 percent) and community-based services (48.8 percent)[85]. Nationally, states allocate approximately three-quarters of SMHA expenditures toward community-based care[85]. This suggests greater reliance on acute and institutional care

settings within Florida's behavioral health system relative to preventive and community-based infrastructure. This is affirmed with only 4 percent of total state SMHA expenditures investing in crisis services while 48 percent of expenditures are applied to state hospital activities (Appendix Table 11).

Comparison of Florida's behavioral health funding sources with selected high-, mid- and low- performing states and national averages suggests a financing structure that differs substantially from many of its peers, described in Table 8. Florida demonstrates relatively high state general revenue investment in behavioral health services, with state government expenditures substantially exceeding the national average. At the same time, Florida reports limited or no Medicaid contribution within this comparison and comparatively lower investment from local funding sources. Additional federal investments, including Mental Health Block Grant (MHBG) supplements and other federal sources, also contribute substantially to Florida's overall behavioral health financing structure and exceed national averages in several categories. These findings suggest that Florida's behavioral health system relies heavily on state appropriations and targeted federal funding mechanisms rather than broader local financing approaches. Variation in financing structures across states further highlights the complexity of comparing behavioral health investments, as differences in Medicaid expansion status, local funding mechanisms, service delivery models, and reporting approaches may substantially influence expenditure patterns.

Table 8. Cross-State and National Comparisons of Behavioral Health Funding

Spending Category	FL	TX	AK	AL	AZ	WY	MA	ME	VT	Nationwide Average	FL Above or Below Average
State Gov.	$485,731,248	$816,048,535	$22,092,324	$442,811,034	$22,735,198	$19,729,343	$835,628,673	$49,734,876	$9,094,981	$192,971,468	▲
Medicaid	$0	$33,585,274	$113,765,814	$125,812,672	$176,526,809	$0	$0	$81,751,053	$237,673,419	$534,250,592	▼
MHBG	$44,929,922	$76,580,582	$2,203,629	$9,935,614	$24,193,677	$1,043,194	$18,926,997	$3,124,617	$604,348	$14,739,880	▲
MHBG Supp.	$42,348,705	$43,174,416	$2,159,628	$500,000	$2,877,897	$2,047,790	$12,462,256	$3,463,345	$1,316,870	$8,886,210	▲
Other Federal	$22,382,266	$36,648,233	$2,856,013	$2,172,887	$1,862,423	$0	$5,854,552	$15,418,087	$8,277,462	$26,920,463	▼
Local	$0	$0	$0	$0	$16,484,352	$0	$0	$0	$0	$35,688,843	▼
Other	$0	$27,874,125	$0	$0	$2,918,487	$0	$10,162,049	$0	$50,206	$21,540,186	▼
Total	**$595,392,141**	**$1,033,911,165**	**$143,077,408**	**$581,232,207**	**$2,475,988,433**	**$22,280,327**	**$883,034,527**	**$153,491,978**	**$257,053,286**		▲

Note: MHBG = Mental Health Block Grant.

Regionally, Florida's low per capita expenditures fit within broader Southern regional trends, but Florida remains among the lowest-spending states nationally even when considering regional differences. Florida's per capita expenditure is identical to Texas ($52.34), a state with a similar population, demand for need, and growth patterns. This may suggest a need to define unique fiscal analysis approaches to account for such conditions.

Cost Management Strategies

Cost management of behavioral health services has evolved over time as systems have shifted away from primarily grant funded to diversified revenue supported through expanded commercial and public coverage and increased investments in special initiatives. Cost management for purposes of this report are the array of strategies and approaches to oversight and quality control with a primary purpose of ensuring public funding is applied to allowable costs, is not excessive for the purpose. There are a variety of cost management strategies applied in the public sector including the use of managed care, utilization review, prior authorization concurrent review policies, cost sharing (premiums, co-pays, deductibles), formularies, Demonstration waivers (1115a), and value-based payments, among others which are summarized in more detail in Table 9.

Table 9. Common Cost Management Strategy Summary Table

Cost Management Strategy*	Definition
Accountable Care Organization	Collective of providers/health systems in partnership designed to reduce overall cost of care and incentivize quality/partnership with incentive payments for meeting specific goals/targets[86].
Managed Care	Organization that either directly provides or arranges managed health care by applying various strategies designed to optimize the value of provided services by controlling their cost and utilization, promoting their quality and measuring performance to ensure cost-effective outcome[87]. Generally financed on a member per month fixed cost.
Medical necessity	Criteria used by a managed care entity to determine if requested interventions or services are medically appropriate and necessary to meet the needs for a particular individual[8687].

Level of care criteria	Guidelines employed to assist in the determination of the appropriate setting and intensity of behavioral health treatment[86].
Utilization review	Prospective and retrospective analysis of the patterns of service usage to determine means for optimizing the value of services provided (e.g. minimize cost and maximize effectiveness/appropriateness)[86]. Prior authorization, concurrent review, and retrospective review are utilization review methods[88].
Prior authorization	process that requires advance approval from a health plan before a specific service is delivered to qualify for payment coverage[89].
Concurrent review	Utilization review process to determine appropriateness of placement for patients already admitted to/or receiving services[90]
Cost-sharing	Premiums, deductibles, co-pays, and coinsurance used to shift costs from a public or private insurer to the consumer[91].
Formulary	List of approved/covered medications by a managed care organization or payor system[92]
Care management/Coordination	Efforts to ensure not that individual services are appropriate but that the totality of services provided to a patient is configured for effectiveness and efficiency. Goals include better outcomes, less system fragmentation, and lower costs[93].
Demonstration waivers	Provides the Secretary of Health and Human Services broad authority to approve projects that test policy innovations likely to further the objectives of the Medicaid program[86][87].
In Lieu of Services	States may authorize managed care organizations to provide alternative services or settings in place of traditional Medicaid State Plan services when the alternative intervention is medically appropriate and expected to reduce or prevent the future need for more intensive or costly services[94].
Value based payments	The concept that payors replace payments for number/volume/types of services with incentives for meeting outcome/performance targets. Providers receive payments tied to quality and cost savings[86].

Note: * Not all strategies assessed in Florida given project limitations.

Florida's Approach to Cost Management

Florida embeds a multitude of cost management strategies to its publicly funded behavioral health system. Unique to Florida is its ME model that passes through state and federal funding to MEs to support uninsured and priority populations with behavioral health conditions (Table 10). Rather than simply administering funding, these entities are charged with planning and oversight of investments and are contractually charged with supporting "efficient and effective delivery of services.[95]" The model mirrors a community-based managed care model and itself functions a cost management approach to streamline oversight, establish consistency

statewide, and ensure necessary resources to adequately manage state investments in community-based behavioral health services. Florida has embedded several cost-management approaches into its standard contract for these agencies including:

- requiring attestation that no other funding source was known for the services invoiced (Section B-6.3)
- requiring annual submissions of quality assurance and network service provider monitoring plans (Section C-1.1.7)
- requiring cost allocation plans, ME spending plans, and a multitude of financial and compliance audit documents (Section C3-2)
- requiring quarterly return on investment reports (C3-6)
- establishing ME performance measures related to network service provider monitoring (Figure 4)
- establishing ME performance measures related to outcomes achieved by network service providers (Figure 5)

Table 10. Managing Entity (ME) Client Eligibility Criteria

ME Client Eligibility Criteria Rollup
➢ Priority admission to pregnant women and women with dependent children by Network Service Providers receiving SAPT Block Grant funding; ➢ Compliance with interim services, for injection drug users, by Network Service Providers receiving SAPT Block Grant funding and treating injection drug users; ➢ Priority for services to families with children that have been determined to require substance abuse and mental health services by child protective investigators and meet the target populations in **Section B-5.3.1** or **Section B-5.3.2**. Such priority shall be limited to individuals that are not enrolled in Medicaid or another insurance program, or require services that are not paid by another payor source: ➢ Parents or caregivers in need of adult mental health services pursuant to s. 394.674(1)(a)2., F.S., based upon the emotional crisis experienced from the potential removal of children; or

- Parents or caregivers in need of adult substance abuse services pursuant to s. 394.674(1)(c)3., F.S., based on the risk to the children due to a substance use disorder.
- Individuals who reside in civil and forensic State Mental Health Treatment Facilities and individuals who are at risk of being admitted into a civil or forensic State Mental Health Treatment Facility;
- Individuals who are voluntarily admitted, involuntarily examined, or placed under Part I, Chapter 394, F.S.;
- Individuals who are involuntarily admitted under Part V, Chapter 397, F.S.;
- Residents of assisted living facilities as required in ss. 394.4574 and 429.075, F.S.;
- Children referred for residential placement in compliance with Ch. 65E-9.008, F.A.C
- Inmates approaching the End of Sentence pursuant to Children and Families Operating Procedure (CFOP) 155-47: "Processing Referrals from the Department of Corrections;" and
- In the event of a Presidential Major Disaster Declaration, Crisis Counseling Program (CCP) services shall be contracted for according to the terms and conditions of any CCP grant award approved by representatives of the Federal Emergency Management Agency (FEMA) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Note: Sourced from https://www.myflfamilies.com/services/samh/providers/managing-entities/FY23-24

Figure 4. Excerpt from ME Contract Exhibit E

Measure Description	Consequence
Systemic Monitoring: The Managing Entity shall complete on-site monitoring, in accordance with **Section C-1.3** of no less than twenty percent of all Network Service Providers each fiscal year. Completion of monitoring includes the release of a final monitoring report to the Network Service Provider. Progress towards attainment of this measure shall be demonstrated by the achievement of the following quarterly milestones. Each fiscal year, the Managing Entity shall monitor a minimum of: **E-1.1** 7% of its Network Service Providers by December 31; **E-1.2** 15% of its Network Service Providers by March 31; and **E-1.3** 20% of its Network Service Providers by June 30.	Failure to meet the standard shall be considered nonperformance pursuant to **Section E-5.**

Note: Sourced from https://www.myflfamilies.com/services/samh/providers/managing-entities/FY23-24

Figure 5. Excerpt from ME Contract Exhibit E

	Target Population and Measure Description	Network Target	Minimum Acceptable Network Performance
Adult Community Mental Health			
MH003	Average annual days worked for pay for adults with severe and persistent mental illness	40	38
MH703	Percent of adults with serious mental illness who are competitively employed	24%	22.8%
MH742	Percent of adults with severe and persistent mental illnesses who live in stable housing environment	90%	85.5%
MH743	Percent of adults in forensic involvement who live in stable housing environment	67%	63.7%
MH744	Percent of adults in mental health crisis who live in stable housing environment	86%	81.7%
Adult Substance Abuse			
SA753	Percentage change in clients who are employed from admission to discharge	10%	9.5%
SA754	Percent change in the number of adults arrested 30 days prior to admission versus 30 days prior to discharge	15%	14.3%
SA755	Percent of adults who successfully complete substance abuse treatment services	51%	48.5%
SA756	Percent of adults with substance abuse who live in a stable housing environment at the time of discharge	94%	89.3%
Children's Mental Health			
MH012	Percent of school days seriously emotionally disturbed (SED) children attended	86%	81.7%
MH377	Percent of children with emotional disturbances (ED) who improve their level of functioning	64%	60.8%
MH378	Percent of children with serious emotional disturbances (SED) who improve their level of functioning	65%	61.8%
MH778	Percent of children with emotional disturbance (ED) who live in a stable housing environment	95%	90.3%
MH779	Percent of children with serious emotional disturbance (SED) who live in a stable housing environment	93%	88.4%
MH780	Percent of children at risk of emotional disturbance (ED) who live in a stable housing environment	96%	91.2%
Children's Substance Abuse			
SA725	Percent of children who successfully complete substance abuse treatment services	48%	45.6%
SA751	Percent change in the number of children arrested 30 days prior to admission versus 30 days prior to discharge	20%	19.0%
SA752	Percent of children with substance abuse who live in a stable housing environment at the time of discharge	93%	88.4%

Note: Sourced from https://www.myflfamilies.com/services/samh/providers/managing-entities/FY23-24

Collectively, the criteria for ME coverage eligibility demonstrate that Florida's publicly funded behavioral health system appropriately prioritizes several populations with elevated clinical, public safety, or statutory needs, including pregnant women, children and families involved with child welfare systems, justice-involved individuals, individuals experiencing behavioral health crises, and individuals at risk of institutional placement. Alternatively, this

structure of categorical eligibility may create challenges for certain individuals who do not meet priority population criteria despite experiencing significant behavioral health needs. This may include lower-income adults and families who are uninsured or underinsured, employed in positions without affordable health benefits, or otherwise ineligible for existing coverage pathways. These individuals may rely disproportionately on limited county indigent-care programs, uncompensated care, and crisis services for behavioral healthcare needs.

To supplement ME contracts, Florida has invested substantial time and expertise to develop Guidance Documents and reporting templates to ensure alignment of service expectations statewide[95]. The level of standardization and accountability management provided in the guidance documents ensures that the programs funded with public dollars are efficient and accountable. Concurrently, outcome measures tied to financial and contractual sanctions ensure that these programs are effective. Given the large volume of individuals supported by ME network service providers, Florida's approach to ME oversight suggests strong financial oversight and application of cost management practices.

Similarly, the AHCA maintains contracts with Medicaid managed care agencies to administer its managed care programs (MMA and LTC). These contracts include a multitude of cost management strategies, including:

- Value-based purchasing performance targets
- Prior authorization
- Demonstration waiver participation
- In Lieu of Services and Settings (ILOS)
- Care management
- Medical necessity criteria

- Formularies

In addition to the model contract, AHCA maintains detailed Exhibits for each of its programs: Exhibit II-A for the Managed Medical Assistance Program, Exhibit II-B for the Long-Term Care Program, and Exhibit II-C for the Intellectual & Developmental Disabilities Comprehensive Managed Care Program. Similar to the Guidance Documents issued for the ME's, these Exhibits outline specific state expectations and criteria for covered services under each program. Each model contract, guidance document, and exhibit publicly available through the DCF and AHCA was reviewed for commonly applied cost management strategies to determine its application in Florida. Throughout, there are a variety of cost management strategies included (Table 11).

Detailed assessment of the implementation, effectiveness, and financial impact of each strategy was beyond the scope of this report given timeline, funding, and capacity constraints. Additionally, publicly financed behavioral health systems often face complex interactions among state agencies, managed care organizations, commercial insurers, providers, and local funding sources that can result in unintended cost shifting across sectors. Future exploration should examine the extent to which reimbursement practices, utilization management, network adequacy, administrative burden, and other financing mechanisms may shift costs from managed care and commercial payors to publicly funded behavioral health systems, providers, and local communities. A more comprehensive analysis of these dynamics could help inform future policy, oversight, and fiscal stewardship efforts while ensuring that public investments are being used as intended.

Table 11. Cost Management Strategies in Florida's Publicly Funded Behavioral Health System

Cost Management Strategy	Applied in Florida	Details
Coverage and Payor-Based		
Prior authorization	**X**	• Prior authorization allowable for SMMC covered services o There are plan sanctions for failure to act timely on PA requests ($2,500 per occurrence). • Prior authorization is unallowable for specific services: (e.g. Child Health Services Targeted Case Management)
Value-based payments	**X**	State model Medicaid managed care contract includes VBP targets for primary care providers.
Demonstration waivers	**X**	State model MCO Medicaid managed care contract requires participation in waiver projects; January 2026 IMD application to CMS with proposed July 1, 2026, start date
In Lieu of Services and Settings		Managed care plan may elect to provide approved ILOS benefits as part of their contracted services (required to obtain state approval prior to implementation). ILOS interventions must represent medically appropriate alternatives that either cost less than traditional covered services or reduce the likelihood of future reliance on higher-acuity services and settings. Florida currently utilizes ILOS mechanisms for several behavioral health-related interventions (See: Appendix Figure 4).
Behavioral Health Parity Oversight	Unknown/ Opportunity for Future Evaluation	No publicly available information identified regarding MHPAEA enforcement activities, corrective actions, market conduct examinations, or parity compliance outcomes. OIG requires plan self-attestation of compliance. Collaborative enforcement agreement established with CMS. Future evaluation could assess the extent to which parity oversight reduces cost shifting to publicly funded systems and improves access to covered behavioral health services.
Contract and Performance Based		
Performance or outcomes-based contracts	X	ME, DCF, MCO contracts with performance measure targets
Financial incentives and/or sanctions in contracts based on quality-of-care indicators, and specified outcomes.	X	ME and MCO contracts with performance measure targets including financial sanctions

Financing and supporting care management/coordination programs	X	ME care management function in required services; care coordination required under MCO contracts.
Financial incentives and/or sanctions based on achieving outcomes for specific subpopulations (e.g. criminal justice, Veterans, pregnant and parenting)	X	Performance measure targets for CJMHSA Reinvestment Grant for target population of justice-involved individuals; ME, DCF, MCO contracts with performance measure targets for priority populations
Provide funds to carry out contract monitoring activities and reporting.	X	Managing Entities funded to support contract management functions; DCF regional and headquarters contract management infrastructure; routine audit schedule for state supported contracts.
Use public (internal or external) disclosure of performance, as appropriate, to push the quality improvement agenda.	X	Annual reports for DCF funded initiatives published and available publicly; required submission of annual reports to key executive and legislative leadership.
Provide funding for the regular dissemination of quality, outcome, and cost-benefit data.	X	DCF and Managing Entity funded evaluation reports; State investment in research, evaluation and technical assistance (e.g. Florida Mental Health Institute, Criminal Justice, Mental Health and Substance Abuse Technical Assistance Center, Baker Act Reporting Center, Florida State University Center for Behavioral Health Integration, Florida Center for Behavioral Health Workforce)

Payment and Reimbursement Models

Beyond contractual oversight and performance requirements, Florida also applies cost management practices at the individual service level with varying payment and reimbursement methodologies designed to support service delivery, accountability, and efficient allocation of public resources. DCF's annual Catalog of Care was used to identify the reimbursement model associated with each service (e.g., fee for service, cost-reimbursement, capitated rate, bundled rate, case rate). Appendix Tables 12-15 specify the model used to fund the different FY24/25 DCF-funded services provided by each ME within each of the four core program areas. Overall, fee for service (FFS) and cost-reimbursement (CR) were approaches that DCF most used to fund many community-based services in each of the four core program areas and three additional non-

core other program areas. Appendix Table 12 presents the reimbursement strategy used to fund each type of community-based adult mental health service (AMH), and Appendix Table 13 presents strategies used to fund each type of adult substance abuse service (ASA). For children's services, Appendix Table 14 shows the strategies used to fund each type of child mental health (CMH) and Appendix Table 15 child substance abuse services (CSA).

Future Considerations for Exploring Cost Management and Effectiveness

Much work has been done to provide the necessary tools and resources to develop financial and quality analysis processes for public and behavioral health systems[86,87,96]. Examples of these tools can be found in Appendix Table 16. Economic evaluation is critical to advancing evidence-based practice and investing taxpayer money in system enhancements that work. There are a wide variety of theories and approaches to assess cost and range from Health Impact Assessments (HIA), Incremental Cost-Effectiveness Ratio (ICER), Cost-Effectiveness Analysis (CEA), Cost-Utility Analysis (CUA) Cost-Benefit Analysis (CBA), and Cost Minimization Analysis (CMA)[97,98,99]. In healthcare and public health settings, cost analyses must consider all consequences and outcomes that programs or investments generate translated at the monetary level. These include health impacts (years of life added, health conditions eliminated or mitigated etc.) and ancillary impacts such as administrative burdens reduced and reduced reliance on justice, education, or child welfare systems. Although beneficial and critically important, the availability and quality of the data to conduct such analyses is difficult to collect and compare across systems with major structural or financial differences, as is affirmed in this report[98].

Florida's behavioral health system has numerous opportunities that exist to further examine the comparative cost-effectiveness of current behavioral health financing and service delivery approaches. These inquiries may include analyses comparing acute and institutional care

expenditures to investments in early intervention, prevention, mobile crisis response, community-based treatment, recovery support services, supportive housing, coordinated care models, and youth wraparound services. Results of such analysis would provide greater insight into the long-term fiscal and systems impacts associated with upstream behavioral health investments relative to reliance on higher-acuity crisis response systems.

An additional area for future exploration is the role of Mental Health Parity and Addiction Equity Act (MHPAEA) compliance and enforcement as a cost-management strategy. Behavioral health parity laws are intended to ensure that mental health and substance use disorder benefits are covered comparably to medical and surgical benefits. When access barriers such as restrictive prior authorization requirements, inadequate provider networks, reimbursement limitations, or other utilization management practices impede access to covered behavioral health services, individuals may experience worsening symptoms and increased reliance on publicly funded crisis, emergency, criminal justice, child welfare, and homelessness response systems. To date, no publicly available information was identified regarding Florida's behavioral health parity enforcement activities, outcomes, or corrective actions. There is no public-facing consumer complaint process specific to reporting coverage and access issues for consumers trying to access behavioral health services. Additional examination of parity compliance and enforcement may provide opportunities to reduce avoidable cost shifting, improve access to covered services, and strengthen fiscal stewardship across public systems.

While the scope, timeline, and resources associated with this report allowed for preliminary exploration of Florida’s approaches to cost management within publicly funded behavioral health systems, additional data infrastructure, longitudinal analysis, and cross-system

financial modeling would be necessary to comprehensively evaluate the state's long-term return on investment.

The recommendations section of this report provides additional detail regarding potential future cost-analysis priorities, comparative service inquiries, and outcome measures for consideration.

Chapter 5: Conclusions

Florida's behavioral health system demonstrates a strong foundational infrastructure, with a broad array of publicly funded services, a well-established managing entity (ME) network, and growing investments in crisis response and care coordination. The state shows moderate alignment with national best practices, particularly in its delegation of regional planning, funding, and service coordination responsibilities through Managing Entity (ME) networks, prioritization of vulnerable populations, and performance oversight mechanisms. These strengths position Florida to continue advancing a more integrated and responsive behavioral health continuum.

This report also identified structural challenges that limit system performance. Florida's relatively low per capita investment in behavioral health, limited Medicaid eligibility participation, and strong reliance on state general revenue and county cost-sharing create constraints on service availability and sustainability. Workforce shortages, particularly among psychiatrists and in rural areas, further contribute to uneven access, while geographic disparities in provider distribution and categorical eligibility requirements leave gaps for uninsured and underinsured populations. Additionally, inconsistent transparency and fragmented data across funding streams hinder comprehensive system evaluation and cost management.

Florida has significant opportunities to strengthen its behavioral health system by increasing investment in community-based and outpatient services, improving financial data transparency, proactively prevent cost-shifting to publicly supported systems, and strategically addressing workforce capacity aligned with shortage areas. Strategic use of Medicaid financing mechanisms, existing enforcement and market conduct opportunities to enforce MHPAEA and prevent cost-shifting, continued development of integrated care models, and targeted efforts to reduce geographic and population-based disparities should be leveraged. By building on existing strengths while addressing identified gaps, Florida can enhance access, improve outcomes, and ensure a more equitable and efficient behavioral health system for its residents.

Chapter 6: Recommendations

Florida has established substantial infrastructure to support publicly funded behavioral health services, including extensive Managing Entity service networks, managed care structures, performance monitoring systems, and multiple financing mechanisms intended to promote accountability and effective use of public resources. The data and reports included in this analysis suggest that the infrastructure for widespread, accountable coverage of behavioral health services is present, particularly if the state's IMD Waiver is approved and implemented as outlined[100]. At the same time, the analyses identified several opportunities to strengthen system performance related to coverage reach, service array, workforce capacity, access to care, transparency, consumer protections, mitigation of cost-shifting to ME networks and counties, and long-term fiscal sustainability.

The recommendations presented below were developed to directly address the requirements outlined in §1004.44, Fla. Stat. (2025), including identification of publicly funded behavioral health services, assessment of quality of care and cost management strategies, and

identification of service areas requiring additional provider capacity. Recommendations also support implementation of Commission on Mental Health and Substance Use Disorder Recommendation 18, which calls for analysis of publicly funded health plan panels for mental health and substance use services. Recommendations were developed through project team and subject matter expert review of the findings contained within this report, examination of emerging national practices and financing strategies, and consideration of existing state infrastructure and resources currently available within Florida's behavioral health system. Where possible, recommendations emphasize strategies that build upon existing infrastructure, promote fiscal stewardship, ensure consumer protection, improve transparency and accountability, and enhance the ability of the behavioral health system to respond effectively to changing population needs.

Recommendations are organized by report aim and include corresponding action items and suggested outcomes that may assist state and local stakeholders in prioritizing activities and evaluating progress over time.

Aim 1: Identify Publicly Funded MH/SUD Services *Supports §1004.44 provider availability requirements and Commission Recommendation 18*		
Statement of Need: Florida supports behavioral health services through multiple agencies and funding streams; however, service definitions, covered benefits, and expenditure categories vary across systems. Findings suggest limited transparency and difficulty comparing service availability, utilization patterns, and investments across agencies and payors.		
Recommendation(s)	**Action Items**	**Suggested Outcomes**
Increase transparency and standardization across publicly funded behavioral health service arrays	Develop standardized reporting categories and definitions across agencies, particularly DCF and AHCA (e.g., outpatient, crisis, residential, recovery support, inpatient)	• Improved consistency in service reporting across agencies • Increased ability to compare expenditures and utilization across funding streams

		• Enhanced visibility of service availability and investment patterns
Develop a statewide behavioral health inventory and dashboard	Create annual public-facing service matrix summarizing service types, populations served, expenditures, and regional availability.	• Improved state and county-wide behavioral health planning capacity • Increased transparency of publicly funded services • Better identification of region-specific service duplication and gaps
Expand understanding of county-level safety-net resources and needs	• Assess county indigent-care programs and identify behavioral health services currently supported and requiring resources • Engage high-priority/high-need counties in exploring the Health Flex program to address unmet behavioral health needs	• Increased understanding of safety-net capacity • Improved coordination between state and local systems • Identification of underserved or under resourced geographic areas
Aim 2: Workforce Availability, Provider Gaps, and Regional Needs *Supports §1004.44 provider availability requirements and Commission Recommendation 18*		
Statement of Need: Geospatial and workforce analyses identified substantial regional variation in provider availability, with shortages most pronounced among psychiatrists, PMHNPs, psychologists, and rural communities. Geographic provider presence and population-adjusted supply did not always align, suggesting access barriers beyond provider counts alone.		
Recommendations	**Action Items**	**Suggested Outcomes**
Prioritize psychiatry and PMHNP workforce expansion	Provide targeted incentives such as loan repayment and scholarship programs tied to employment in shortage areas and expanding residency slots and in-state training pipelines	• Psychiatrist, PMHNP, psychologist, and behavioral health provider-to-population ratios • Number and distribution of providers practicing in shortage areas • Workforce vacancy and retention rates

		• Reductions in waiting lists; expanded access to care
Expand satellite, mobile, consultative telehealth, and co-located behavioral health models	Use hotspot analyses, drive-time analyses, and population trends to identify target regions	• Average travel distance and travel time to behavioral health services • Service availability within identified shortage areas • Utilization trends in newly served regions
Expand integrated primary care–behavioral health models	• Support co-location and behavioral health consultation models (e.g. Certified Community Behavioral Health Clinics, Project ECHO models) • Target healthcare provider engagement to expand access to medication and early intervention gaps in key shortage areas (e.g. SBIRT initiatives, MOUD prescriber/specialized training for PCPs)	• Number of primary care settings with behavioral health integration • Behavioral health screening and referral rates • Rates of treatment initiation following identification
Increase awareness and utilization of Early, Periodic Screening, Diagnoses, and Treatment coverage mechanisms and youth behavioral health benefits	Develop provider education initiatives and technical assistance to youth-serving agencies	• EPSDT behavioral health utilization trends • Rates of preventive and early intervention service use • Youth behavioral health service access indicators
Explore nontraditional workforce approaches	Expand peer service coverage and reach, telehealth, and faith/community partnerships.	• Peer service utilization trends • Telebehavioral health utilization by region • Service penetration in rural and underserved areas • Partners and nontraditional

		sectors engaged in partnerships
Aim 3: 3A/3B: Cost Management and Service Costs *Supports §1004.44 assessment of quality and cost management*		
Statement of Need: Florida demonstrates substantial infrastructure for oversight, financing, and administration of publicly funded behavioral health services. Opportunities remain to improve transparency of expenditures and utilization, assess the effectiveness of current investments, and evaluate operational factors that influence access, quality, and consumer experience. Strengthening these areas may improve accountability and support efficient use of public resources.		
Recommendations	**Action Items**	**Suggested Outcomes**
Increase transparency regarding behavioral health expenditures and utilization	Publicly report expenditures by service type and care setting	• Annual expenditure reporting by service category • Utilization patterns by level of care • Distribution of investments across service settings
Evaluate comparative effectiveness of current investment strategies	Conduct targeted analyses comparing acute care expenditures with prevention, outpatient care, and community-based stabilization approaches	• Comparative costs across service settings • Emergency department utilization patterns • Hospitalization and readmission trends
Expand use of value-based purchasing approaches for behavioral health services	Review behavioral health provider eligibility within existing Medicaid managed care value-based purchasing eligibility criteria.	• Utilization of performance-based contracting mechanisms • Quality measure performance trends • Alignment of payment approaches with outcomes
Explore innovative financing models and federal opportunities	Assess use of Medicaid waivers (1115a) and other financing approaches implemented in peer states, including: o Reentry	• Economic evaluation capacity across agencies and contractors

	o Health Related Social Needs- to address access to care issues related to homelessness, income, and risk population. o Use of In Lieu of Services and Settings	• Use of cost analyses in planning activities • Integration of financial performance data into decision-making
Promote economic evaluation literacy across agencies and contractors	Encourage use of CDC POLARIS or related free and evidence-supported training and economic evaluation resources (e.g. Cost-Effectiveness Analysis Registry)	• Economic evaluation capacity across agencies and contractors • Use of cost analyses in planning activities • Integration of financial performance data into decision-making
Strengthen consumer protection and accountability mechanisms for behavioral health coverage	Increase awareness of existing complaint and appeals processes; coordinate across AHCA, DCF, Office of the Attorney General, OIR, and consumer resources	• Consumer complaint and appeals utilization patterns • Trends in reported access barriers • Resolution and response time indicators
Establish centralized behavioral health access and reporting resources for publicly and commercially insured populations	Establish public-facing complaint and appeals processes to identify red flag policies and practices Develop a single portal for network concerns, access barriers, and reporting issues	• Availability of system-wide access data • Identification of common service barriers • Trends in network and access concerns • Increased awareness of consumer protections
Evaluate operational access to covered services	Assess provider directory accuracy, appointment availability, and network functionality	• Provider directory accuracy • Appointment availability and wait time indicators

		• Network adequacy and provider participation measures
Review approaches to cost management in managed care for behavioral health providers	Assess prior authorization requirements, reimbursement structures, and administrative burden for behavioral health services in Managed Care contracts, particularly for high-need populations	• Prior authorization utilization and turnaround patterns • Service approval and denial trends • Administrative burden indicators • Emergency department and crisis care utilization patterns
Strengthen oversight of publicly funded behavioral health coverage as a fiscal stewardship strategy to reduce cost shifting and protect public investments.	Conduct a comprehensive assessment of behavioral health-related cost shifting from Medicaid managed care and commercial plans to publicly funded systems, including the impact of claim denials, underpayment, network inadequacy, utilization management practices, and administrative burden on providers. Evaluate the extent to which public funds are being used to subsidize services for individuals who are enrolled in managed care plans but unable to access adequately reimbursed covered services. Assess provider financial viability across critical service sectors, including crisis stabilization, children's crisis services, residential treatment, and community-based behavioral health programs.	• Quantification of behavioral health cost shifting from managed care and commercial insurers to publicly funded behavioral health systems. • Increased transparency regarding the relationship between managed care reimbursement practices, provider sustainability, and public behavioral health expenditures. • Identification of service sectors and providers at greatest risk of financial instability due to underpayment, claim denials, or administrative burden. • Recommendations to strengthen oversight of managed care

		behavioral health obligations, including parity, network adequacy, and reimbursement practices. • Reduced reliance on public funding to offset costs associated with inadequately reimbursed covered services. • Reinvestment opportunities identified to strengthen community-based behavioral health services, crisis system capacity, workforce stability, and provider sustainability.

APPENDIX

Table 1. FY24/25 DCF-Funded Community-Based Core Program Area Adult Mental Health (AMH) Services by Managing Entity (ME)

DCF-Funded Community-Based Adult Mental Health (AMH) Services	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	CFBHN	CFCHS	LSF	NFHN	SFBHN	SEFBHN
Aftercare							
Assessment	X	X	X	X	X	X	X
Behavioral Health Network (BNET)							
Care Coordination	X		X	X	X	X	X
Case Management	X	X	X	X	X	X	X
Central Receiving System				X			X
Community Action Team (CAT Team)			X				
Comprehensive Community Service Team (CCST)						X	X
Cost Reimbursement				X		X	
Crisis Stabilization	X	X	X	X	X	X	X
Crisis Support/Emergency	X	X	X	X	X	X	X
Day Care				X			
Day Treatment	X	X		X	X	X	X
Disaster Behavioral Health			X				
Drop In/Self-Help Centers	X	X	X	X	X	X	X
Family Intensive Treatment Team (FIT Team)					X		
Federal Project Grant	X		X		X		
First Episode Team			X	X	X	X	X
Florida Assertive Community Treatment Team (FACT Team)	X	X	X	X	X	X	X
Florida's Coordinated Opioid Recovery (CORE) Network of Addiction Care							
Forensic Local Diversion Project	X						
Forensic Multidisciplinary Team	X	X		X	X	X	X
HIV Early Intervention Services							
Incidental Expenses	X	X	X	X	X	X	X
Information and Referral	X	X		X	X	X	X
In-Home and On-Site	X	X	X	X	X	X	X
Inpatient			X	X			
Intensive Case Management		X	X	X			X
Intervention	X	X	X	X		X	X
Local Forensic Diversion Project				X			
Medical Services	X	X	X	X	X	X	X
Medication Assisted Treatment							
Mental Health Clubhouse Services	X	X	X	X		X	X
Multidisciplinary Child Welfare Teams							

DCF-Funded Community-Based Adult Mental Health (AMH) Services	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	CFBHN	CFCHS	LSF	NFHN	SFBHN	SEFBHN
Network Evaluation & Development		X	X	X		X	X
Opioid Settlement - Non-Qualified County (NQC)							
Other Bundled Projects	X	X	X	X	X	X	X
Other Bundled Projects (Transitional Beds for MH Institution)				X			
Other Multidisciplinary Team				X			
Outpatient	X	X	X	X	X	X	X
Outreach	X	X	X	X	X	X	X
Prevention - Indicated	X					X	
Prevention - Selective	X					X	
Prevention - Universal Direct	X					X	
Prevention - Universal Indirect	X					X	
Provider Proviso Projects		X	X	X	X		X
Recovery Support	X	X	X	X		X	X
Residential Level I	X	X				X	X
Residential Level II	X	X	X	X	X	X	X
Residential Level III	X	X	X		X		X
Residential Level IV	X	X	X	X	X	X	X
Respite Services	X			X			X
Room and Board with Supervision Level I	X				X		
Room and Board with Supervision Level II	X	X	X	X	X	X	X
Room and Board with Supervision Level III	X		X	X		X	
Room and Board with Supervision Level IV				X			
Self- Directed Care		X					
Short-Term Residential Treatment	X	X	X		X	X	X
Start-Up Cost Reimbursement			X		X	X	X
Substance Abuse Inpatient Detoxification			X	X			
Substance Abuse Outpatient Detoxification							
Supported Employment	X	X		X	X	X	X
Supportive Housing/Living	X	X	X	X	X	X	X
Treatment Alternative for Safer Communities (TASC)							
Wraparound			X		X		

Table 2. FY24/25 DCF-Funded Community-Based Core Program Area Adult Substance Abuse (ASA) Services by Managing Entity (ME)

DCF-Funded Community-Based Adult Substance Abuse (ASA) Services	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	CFBHN	CFCHS	LSF	NFHN	SFBHN	SEFBHN
Aftercare	X	X	X	X	X	X	X
Assessment	X	X	X	X	X	X	X
Behavioral Health Network (BNET)							
Care Coordination	X		X	X	X	X	X
Case Management	X	X	X	X	X	X	X
Central Receiving System							
Community Action Team (CAT Team)							
Comprehensive Community Service Team (CCST)							X
Cost Reimbursement							
Crisis Stabilization							
Crisis Support/Emergency	X	X	X	X	X	X	X
Day Care		X		X			
Day Treatment	X	X	X		X	X	X
Disaster Behavioral Health							
Drop In/Self-Help Centers							
Family Intensive Treatment Team (FIT Team)	X	X	X	X	X		X
Federal Project Grant	X		X		X	X	X
First Episode Team							
Florida Assertive Community Treatment Team (FACT Team)							
Florida's Coordinated Opioid Recovery (CORE) Network of Addiction Care				X			
Forensic Local Diversion Project							
Forensic Multidisciplinary Team							
HIV Early Intervention Services	X						X
Incidental Expenses	X	X	X	X	X	X	X
Information and Referral	X	X	X	X		X	X
In-Home and On-Site	X					X	X
Inpatient							
Intensive Case Management							
Intervention	X	X	X	X	X	X	X
Local Forensic Diversion Project							
Medical Services	X	X	X	X	X	X	X
Medication Assisted Treatment	X	X	X	X	X	X	X
Mental Health Clubhouse Services							
Multidisciplinary Child Welfare Teams		X					
Network Evaluation & Development		X	X	X	X		X
Opioid Settlement - Non-Qualified County (NQC)				X			

DCF-Funded Community-Based Adult Substance Abuse (ASA) Services	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	CFBHN	CFCHS	LSF	NFHN	SFBHN	SEFBHN
Other Bundled Projects	X		X	X	X	X	X
Other Bundled Projects (Transitional Beds for MH Institution)							
Other Multidisciplinary Team							
Outpatient	X	X	X	X	X	X	X
Outreach	X	X	X	X	X	X	X
Prevention - Indicated	X	X	X	X	X	X	X
Prevention - Selective	X	X	X	X	X	X	
Prevention - Universal Direct	X	X	X	X	X	X	X
Prevention - Universal Indirect	X	X	X	X	X	X	X
Provider Proviso Projects	X		X	X			
Recovery Support	X	X	X	X	X	X	X
Residential Level I	X	X	X	X			X
Residential Level II	X	X	X	X	X	X	X
Residential Level III	X	X	X		X	X	X
Residential Level IV	X	X	X		X	X	X
Respite Services	X			X			X
Room and Board with Supervision Level I							
Room and Board with Supervision Level II	X	X	X	X	X	X	X
Room and Board with Supervision Level III		X		X			X
Room and Board with Supervision Level IV							
Self- Directed Care							
Short-Term Residential Treatment							
Start-Up Cost Reimbursement		X	X			X	X
Substance Abuse Inpatient Detoxification	X	X	X	X	X	X	X
Substance Abuse Outpatient Detoxification	X						
Supported Employment	X						X
Supportive Housing/Living	X	X	X	X			
Treatment Alternative for Safer Communities (TASC)			X		X		X
Wraparound							

Table 3. FY24/25 DCF-Funded Community-Based Core Program Area Child Mental Health (CMH) Services by Managing Entity (ME)

DCF-Funded Community-Based Child Mental Health (CMH) Services	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	CFBHN	CFCHS	LSF	NFHN	SFBHN	SEFBHN
Aftercare							
Assessment	X	X	X	X	X	X	X
Behavioral Health Network (BNET)	X	X	X	X	X	X	X
Care Coordination	X			X	X		X
Case Management	X	X	X	X	X	X	X
Central Receiving System					X		
Community Action Team (CAT Team)	X	X	X	X	X	X	X
Comprehensive Community Service Team (CCST)						X	X
Cost Reimbursement				X			
Crisis Stabilization	X	X	X	X	X	X	X
Crisis Support/Emergency	X	X	X	X	X	X	X
Day Care							
Day Treatment	X			X			
Disaster Behavioral Health							
Drop In/Self-Help Centers							
Family Intensive Treatment Team (FIT Team)							
Federal Project Grant							
First Episode Team		X	X		X		
Florida Assertive Community Treatment Team (FACT Team)							
Florida's Coordinated Opioid Recovery (CORE) Network of Addiction Care							
Forensic Local Diversion Project							
Forensic Multidisciplinary Team							
HIV Early Intervention Services							
Incidental Expenses	X	X	X	X		X	X
Information and Referral	X	X		X		X	X
In-Home and On-Site	X	X	X	X		X	X
Inpatient	X		X				
Intensive Case Management				X			X
Intervention	X	X	X	X	X	X	X
Local Forensic Diversion Project							
Medical Services	X	X	X	X	X	X	X
Medication Assisted Treatment							
Mental Health Clubhouse Services							
Multidisciplinary Child Welfare Teams		X					
Network Evaluation & Development			X				X
Opioid Settlement - Non-Qualified County (NQC)							

DCF-Funded Community-Based Child Mental Health (CMH) Services	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	CFBHN	CFCHS	LSF	NFHN	SFBHN	SEFBHN
Other Bundled Projects	X	X	X	X	X	X	X
Other Bundled Projects (Transitional Beds for MH Institution)							
Other Multidisciplinary Team							
Outpatient	X	X	X	X	X	X	X
Outreach	X	X	X	X	X	X	X
Prevention - Indicated	X						
Prevention - Selective	X						
Prevention - Universal Direct	X						X
Prevention - Universal Indirect	X						
Provider Proviso Projects	X	X		X	X		X
Recovery Support	X		X	X		X	X
Residential Level I	X	X				X	X
Residential Level II							X
Residential Level III							
Residential Level IV							
Respite Services	X		X				X
Room and Board with Supervision Level I			X				
Room and Board with Supervision Level II			X	X			X
Room and Board with Supervision Level III							
Room and Board with Supervision Level IV							
Self- Directed Care							
Short-Term Residential Treatment						X	
Start-Up Cost Reimbursement			X		X	X	X
Substance Abuse Inpatient Detoxification							
Substance Abuse Outpatient Detoxification							
Supported Employment	X						
Supportive Housing/Living	X						X
Treatment Alternative for Safer Communities (TASC)							
Wraparound				X			

Table 4. FY24/25 DCF-Funded Community-Based Core Program Area Child Substance Abuse (CSA) Services by Managing Entity (ME)

DCF-Funded Community-Based Child Substance Abuse (CSA) Services	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	CFBHN	CFCHS	LSF	NFHN	SFBHN	SEFBHN
Aftercare							
Assessment	X	X	X	X	X	X	X
Behavioral Health Network (BNET)							
Care Coordination	X		X	X	X	X	X
Case Management	X	X	X	X	X	X	X
Central Receiving System				X			X
Community Action Team (CAT Team)			X				
Comprehensive Community Service Team (CCST)						X	X
Cost Reimbursement				X		X	
Crisis Stabilization	X	X	X	X	X	X	X
Crisis Support/Emergency	X	X	X	X	X	X	X
Day Care				X			
Day Treatment	X	X		X	X	X	X
Disaster Behavioral Health			X				
Drop In/Self-Help Centers	X	X	X	X	X	X	X
Family Intensive Treatment Team (FIT Team)					X		
Federal Project Grant	X		X		X		
First Episode Team			X	X	X	X	X
Florida Assertive Community Treatment Team (FACT Team)	X	X	X	X	X	X	X
Florida's Coordinated Opioid Recovery (CORE) Network of Addiction Care							
Forensic Local Diversion Project	X						
Forensic Multidisciplinary Team	X	X		X	X	X	X
HIV Early Intervention Services							
Incidental Expenses	X	X	X	X	X	X	X
Information and Referral	X	X		X	X	X	X
In-Home and On-Site	X	X	X	X	X	X	X
Inpatient			X	X			
Intensive Case Management		X	X	X			X
Intervention	X	X	X	X		X	X
Local Forensic Diversion Project				X			
Medical Services	X	X	X	X	X	X	X
Medication Assisted Treatment							
Mental Health Clubhouse Services	X	X	X	X		X	X
Multidisciplinary Child Welfare Teams							
Network Evaluation & Development		X	X	X		X	X
Opioid Settlement - Non-Qualified County (NQC)							

DCF-Funded Community-Based Child Substance Abuse (CSA) Services	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	CFBHN	CFCHS	LSF	NFHN	SFBHN	SEFBHN
Other Bundled Projects	X	X	X	X	X	X	X
Other Bundled Projects (Transitional Beds for MH Institution)				X			
Other Multidisciplinary Team				X			
Outpatient	X	X	X	X	X	X	X
Outreach	X	X	X	X	X	X	X
Prevention - Indicated	X					X	
Prevention - Selective	X					X	
Prevention - Universal Direct	X					X	
Prevention - Universal Indirect	X					X	
Provider Proviso Projects		X	X	X	X		X
Recovery Support	X	X	X	X		X	X
Residential Level I	X	X				X	X
Residential Level II	X	X	X	X	X	X	X
Residential Level III	X	X	X		X		X
Residential Level IV	X	X	X	X	X	X	X
Respite Services	X			X			X
Room and Board with Supervision Level I	X				X		
Room and Board with Supervision Level II	X	X	X	X	X	X	X
Room and Board with Supervision Level III	X		X	X		X	
Room and Board with Supervision Level IV				X			
Self- Directed Care		X					
Short-Term Residential Treatment	X	X	X		X	X	X
Start-Up Cost Reimbursement			X		X	X	X
Substance Abuse Inpatient Detoxification			X	X			
Substance Abuse Outpatient Detoxification							
Supported Employment	X	X		X	X	X	X
Supportive Housing/Living	X	X	X	X	X	X	X
Treatment Alternative for Safer Communities (TASC)							
Wraparound			X		X		

Table 5. AHCA FFS Service Array

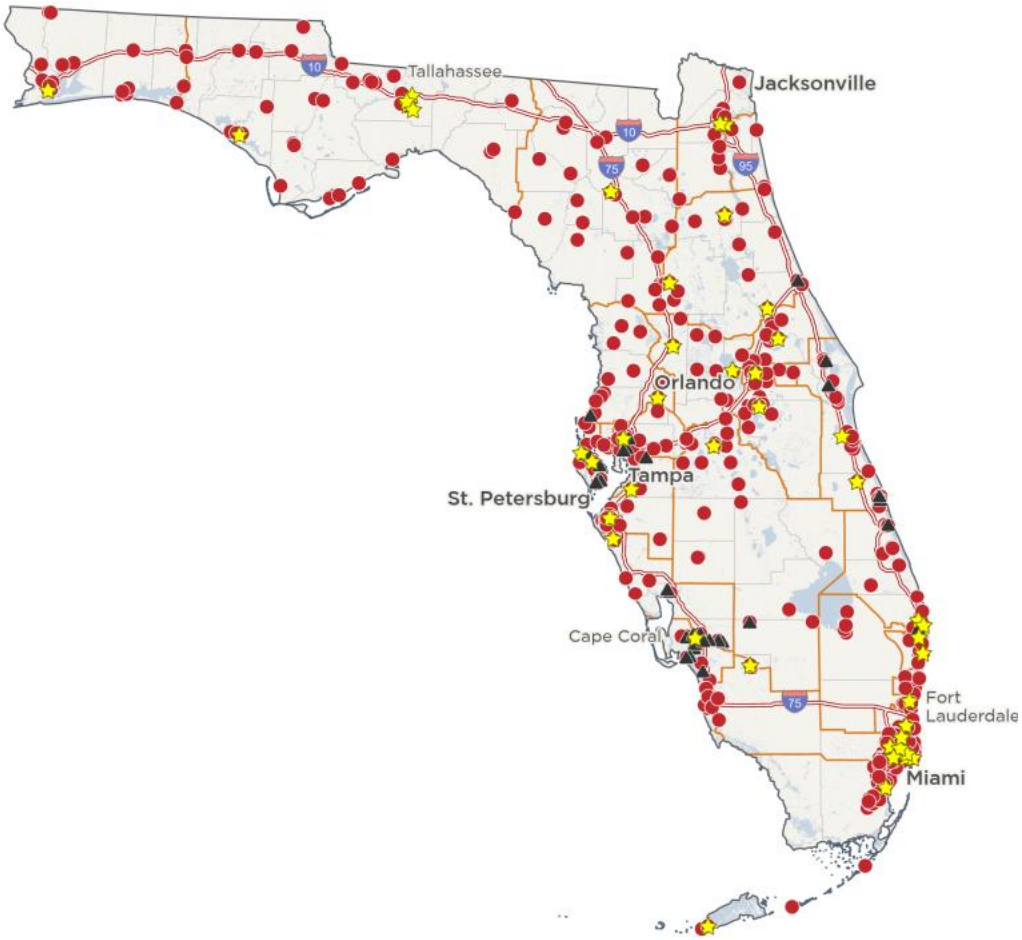
Description of Service	Population	Procedure Code
Behavior identification - assessment	C	97151
Behavior Reassessment	C	
Behavior identification - supporting assessment	C	97152
Behavior treatment by protocol	C	97153
Group BA services by protocol, two clients in group	C	97154
Group BA services protocol, three clients in group	C	
Group BA services by protocol, four clients in group	C	
Group BA services by protocol, five clients in group	C	
Group BA services by protocol, six clients in group	C	
Behavior treatment with protocol modification	C	97155
Behavior treatment with protocol modification	C	
Family training by Lead Analyst	C	97156
Family training via telemedicine	C	
Family training by assistant	C	
Group BA services with protocol modification, two clients	C	97158
Group BA services with protocol modification, three clients	C	
Group BA services with protocol modification, four clients	C	
Group BA services with protocol modification, five clients	C	
Group BA services with protocol modification, six clients	C	
Assessment add-on practitioner	C	0362T
Treatment add-on practitioner	C	0373T
In-depth assessment, new patient, substance abuse	A/C	H0001
In-depth assessment, established patient, substance abuse	A/C	
Bio-psychosocial evaluation, substance abuse	A/C	
Limited functional assessment, substance abuse	A/C	
Individual service evaluation	C	H0002
Therapeutic group care services	C	H0019
Qualified Residential Treatment Program (QRTP) Services	C	
Medication-assisted treatment services	A/C	H0020
Substance use intervention service	A/C	H0022
Comprehensive behavioral health assessment		H0031
Individual service evaluation	C	
In-depth assessment, new patient, mental health	A/C	
In-depth assessment, established patient, mental health	A/C	
Bio-psychosocial Evaluation, mental health	A/C	

Limited functional assessment, mental health	A/C	H0032
Treatment plan development, new and established patient, mental health	A/C	
Treatment plan review, mental health	A/C	
Florida Assertive Community Treatment	A/C	H0040
Behavioral health-related medical services: verbal interaction, mental health	A/C	H0046
Group Service	C	
Individual Service - All else	C	
Behavioral health-related medical services: verbal interaction, substance abuse	A/C	H0047
Behavioral health-related medical services: alcohol and other drug screening specimen	A/C	H0048
Psychiatric evaluation by a non-physician	A/C	H2000
Psychiatric review of records	A/C	
Psychiatric evaluation by a physician	A/C	
Brief behavioral health status exam	A/C	H2010
Brief individual medical psychotherapy, mental health	A/C	
Brief individual medical psychotherapy, substance abuse	A/C	
Brief group medical therapy	A/C	
Behavioral health day services, mental health	A/C	H2012
Behavioral health day services, substance abuse	A/C	
ABA Individual Service	C	H2014
ABA Group Service	C	
Comprehensive community support services for substance abuse: Aftercare	A/C	H2015
Comprehensive community support services: Individual peer recovery	A/C	
Comprehensive community support services: Group peer recovery	A/C	
Psychosocial rehabilitation services	A/C	H2017
Psychological testing	A/C	H2019
Group Service	C	
Individual Service - All else	C	
Therapeutic behavioral on-site services, therapy	A/C	
Therapeutic behavioral on-site services, behavior management	A/C	
Therapeutic behavioral on-site services, therapeutic support	A/C	
Individual and family therapy	A/C	
Group therapy	A/C	
Behavioral health overlay services	A?	H2020
Clubhouse services	A/C	H2030

Treatment plan development, new and established patient, substance abuse	A/C	T1007
Treatment plan review, substance abuse	A/C	
Medication management	A/C	T1015
Behavioral health-related medical services: medical procedures, mental health	A/C	
Behavioral health-related medical services: medical procedures, substance abuse	A/C	
Targeted Case Management	A/C	T1017
Intensive Team Targeted Case Management	A	
Behavioral health medical screening, mental health	A/C	T1023
Behavioral health medical screening, substance abuse	A/C	

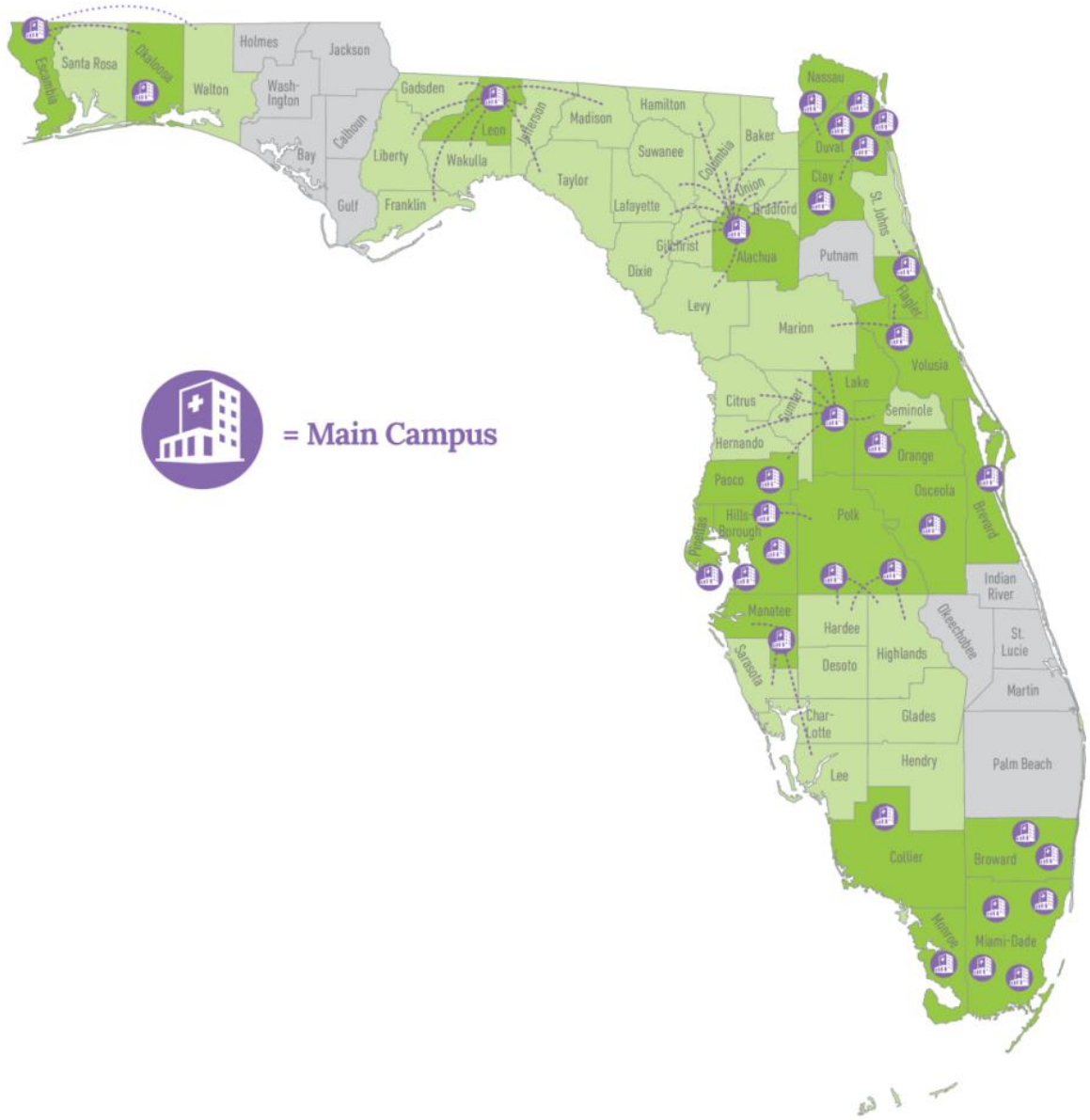
Note: Population A is Adult and C is Child, though ages are not consistently defined. Similarly, given that many adult services are also available as required by law to eligible recipients under the age of 21 years (traditional definition of 'child'), those services are listed as available to children.

Figure 1. Florida's Federally Qualified Health Center Delivery Sites



Note: Source from https://www.nachc.org/wp-content/uploads/2025/01/Florida.pdf

Figure 2. Florida's Certified Community Behavioral Health Clinics



Note: Sourced from https://floridabha.org/ccbhc/

Appendix Narrative 1.

Overview

A combined geospatial and supply and demand modeling approach was used to assess behavioral health service availability, workforce capacity, and population-level demand across Florida. Geospatial analyses identified geographic patterns in behavioral health provider locations and visually assessed potential service gaps using point-based spatial representation. County-level workforce supply and demand were analyzed using licensure data from the Florida Department of Health and multiple population-based indicators, including Behavioral Risk Factor Surveillance System measures, Baker Act data, and population estimates. Workforce supply was estimated across six behavioral health professions over time and demand was modeled dynamically using a composite behavioral health risk indicator.

Data Collection

Provider location data were compiled from multiple publicly available and administrative sources between January, 2026 and May, 2026. Medicare- and Medicaid-funded behavioral health treatment provider locations were obtained from the Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Locator[i]. Managing entity (ME) provider location data were obtained directly from each Florida managing entity via email request coordinated with assistance from the Florida Association of Managing Entities (FAME) to ensure completeness and standardization across regions. Medicare-, Medicaid-, and ME-funded data represented the most recent provider listings at the time of extraction and included both adult and child-serving substance use and mental health treatment providers.

Workforce supply projections with population-based estimates of service demand across Florida counties focused on six core behavioral health professions: Licensed Clinical Social

Workers (LCSWs), Licensed Mental Health Counselors (LMHCs), Licensed Marriage and Family Therapists (LMFTs), Clinical Psychologists, Psychiatrists, and Psychiatric Mental Health Nurse Practitioners (PMHNPs). The Florida Department of Health licensure database provided the workforce data used in the analysis[ii]. The demand estimates incorporated multiple population-level indicators of behavioral health need. The analysis used Behavioral Risk Factor Surveillance System (BRFSS) indicators of mental health, substance use, and barriers to treatment, along with Baker Act examination data, population estimates from the Florida Office of Economic and Demographic Research, and U.S. Census demographic projections[iii],[iv],[v]. Initial benchmark provider-to-population ratios anchored the demand estimates in 2017, but the models allowed demand to change dynamically over time as behavioral health risk indicators, population growth, Baker Act examinations, suicide rates, and overdose trends changed.

Data Preparation

Provider records were cleaned to remove duplicates across sources. Deduplication was conducted using a combination of provider name, address, and geographic coordinates to ensure unique representation of service locations. Latitude and longitude coordinates were verified for completeness and accuracy prior to mapping. Records with missing location information or PO box locations (e.g., where physical location of services was not the same) were excluded from spatial visualization. The final analytic dataset represented a consolidated, non-duplicated set of publicly funded behavioral health provider locations across Florida.

Provider activity was reconstructed over time using the “Original Date” associated with licensure issuance and the “Status Effective Date” associated with changes in license status. Providers with active “Clear” licenses were treated as active through 2024, while providers with inactive or changed statuses were considered active only between the original licensure date and

the status change date. This approach allowed the analysis to estimate yearly provider counts for each profession across Florida counties. Demand modelling combined BRFSS indicators, Baker Act examinations, suicide rates, and drug overdose data into a behavioral health risk variable allowing projected workforce demand to respond to changes in behavioral health conditions across Florida communities.

Spatial Analysis

All provider locations were mapped using latitude and longitude coordinates where point features represented individual provider sites. A dot density-style point map was used to visualize the spatial distribution of behavioral health service providers. Each provider location was represented as a discrete point feature to enable direct observation of geographic clustering, dispersion, and relative service concentration across regions of Florida. This approach was selected to preserve locational precision and avoid aggregation bias associated with polygon-based representations (e.g., zip code tabulation areas or census tracts). The resulting spatial pattern was used to qualitatively assess areas of higher provider density as well as regions with sparse or absent provider presence, which were interpreted as potential service gaps. All spatial data processing, integration, and visualization were conducted using ArcGIS Pro[vi]. Data cleaning and preprocessing were completed using Microsoft Excel prior to import into the GIS environment.

Supply and Demand

The provider supply models addressed several statistical challenges common in workforce data. Provider counts were positively skewed (many counties contained few providers while some contained many providers), contained substantial overdispersion, and included many county-year combinations with zero providers, particularly for rural counties and smaller

professions such as psychiatrists and LMFTs. To address these issues, the analysis used random effects hurdle negative binomial models. These models separated the process governing whether a county had any providers at all from the process governing provider growth once a workforce was established. The hurdle component estimated the probability that a county crossed from zero providers to some positive workforce capacity, while the count component modeled changes in provider counts conditional on provider presence. Random effects accounted for clustering and variability across counties. The modeling strategy also addressed differences in how professions expanded over time. Traditional negative binomial models use a log link, which assumes multiplicative growth where workforce counts increase proportionally over time. However, several professions appeared to grow more linearly, with provider counts increasing by relatively constant amounts rather than percentages. To better reflect these patterns while still ensuring predicted values remained positive, the analysis incorporated a softplus link function for selected professions. The softplus transformation approximated linear growth while preserving the desirable statistical properties of count models. This approach allowed the analysis to distinguish professions characterized by multiplicative expansion from those showing more incremental additive growth

[i] Substance Abuse and Mental Health Services Administration. (n.d.). FindTreatment.gov. https://findtreatment.gov/

[ii] Florida Department of Health, Division of Medical Quality Assurance. (n.d.). MQA data download portal.

[iii] Centers for Disease Control and Prevention. (n.d.). 2024 BRFSS survey data and documentation. https://www.cdc.gov/brfss/annual_data/annual_2024.ht

[iv] Florida Office of Economic and Demographic Research. (2024). County population, 2024. https://edr.state.fl.us/content/population-demographics/data/CountyPopulation_2024.pdf

[v] U.S. Census Bureau. (n.d). American Community Survey microdata. https://www.census.gov/programs-surveys/acs/microdata.html

[vi] Esri. (2024). *ArcGIS Pro* (Version 3.3.2) [Software]. https://www.esri.com/en-us/arcgis/products/arcgis-pro/overview

Table 6. County-Level Provider Counts per 100,000 people.

County	Population	Deduplicated Count	Deduplicated sites (ME + AHCA) per 100k	ME-Funded Provider Count	ME sites per 100k	AHCA-Funded Provider Count	AHCA sites per 100k
Alachua	278468	23	8.26	17	6.10	8	2.87
Baker	28259	2	7.08	2	7.08	1	3.54
Bay	175216	20	11.41	19	10.84	5	2.85
Bradford	28303	1	3.53	1	3.53	2	7.07
Brevard	606612	32	5.28	34	5.60	15	2.47
Broward	1944375	129	6.63	174	8.95	29	1.49
Calhoun	13648	3	21.98	2	14.65	1	7.33
Charlotte	186847	11	5.89	12	6.42	5	2.68
Citrus	153843	25	16.25	21	13.65	7	4.55
Clay	218245	55	25.20	57	26.12	4	1.83
Collier	375752	10	2.66	8	2.13	7	1.86
Columbia	69698	4	5.74	5	7.17	2	2.87
DeSoto	33976	5	14.72	5	14.72		
Dixie	16759	2	11.93	2	11.93	2	11.93
Duval	995567	50	5.02	48	4.82	15	1.51
Escambia	321905	16	4.97	19	5.90	4	1.24
Flagler	115378	6	5.20	5	4.33	4	3.47
Franklin	12451	3	24.09	4	32.13	1	8.03
Gadsden	43826	8	18.25	6	13.69	3	6.85
Gilchrist	17864	1	5.60	1	5.60	1	5.60
Glades	12126	4	32.99	4	32.99		
Gulf	14192	2	14.09	2	14.09	2	14.09
Hamilton	14004	1	7.14	1	7.14	1	7.14
Hardee	25327	3	11.85	4	15.79	1	3.95
Hendry	39619	8	20.19	8	20.19	1	2.52
Hernando	194515	9	4.63	8	4.11	4	2.06
Highlands	101235	11	10.87	20	19.76	1	0.99
Hillsborough	1459762	72	4.93	77	5.27	23	1.58
Holmes	19653	4	20.35	4	20.35	1	5.09
Indian River	159788	7	4.38	6	3.75	4	2.50
Jackson	47319	5	10.57	5	10.57		
Jefferson	14510	2	13.78	2	13.78	1	6.89
Lafayette		0	0.00	0	0.00	0	0.00
Lake	383956	18	4.69	15	3.91	14	3.65
Lee	760822	26	3.42	24	3.15	9	1.18
Leon	292198	35	11.98	37	12.66	16	5.48
Levy	42915	2	4.66	2	4.66	2	4.66

Liberty	7974	2	25.08	2	25.08		
Madison	17968	2	11.13	2	11.13	1	5.57
Manatee	399710	16	4.00	15	3.75	5	1.25
Marion	375908	18	4.79	14	3.72	15	3.99
Martin	158431	15	9.47	11	6.94	5	3.16
Miami-Dade	2701767	104	3.85	79	2.92	62	2.29
Monroe	82874	5	6.03	1	1.21	2	2.41
Nassau	90352	7	7.75	6	6.64	5	5.53
Okaloosa	211668	5	2.36	4	1.89	1	0.47
Okeechobee	39644	6	15.13	7	17.66	2	5.04
Orange	1429908	41	2.87	32	2.24	22	1.54
Osceola	388656	19	4.89	16	4.12	9	2.32
Palm Beach	1492191	43	2.88	37	2.48	11	0.74
Pasco	561891	37	6.58	43	7.65	12	2.14
Pinellas	959107	56	5.84	43	4.48	26	2.71
Polk	725046	60	8.28	63	8.69	12	1.66
Putnam	73321	10	13.64	10	13.64	4	5.46
St. Johns	273425	15	5.49	14	5.12	6	2.19
St. Lucie	329226	22	6.68	16	4.86	11	3.34
Santa Rosa	188000	7	3.72	6	3.19	1	0.53
Sarasota	434006	23	5.30	30	6.91	6	1.38
Seminole	470856	18	3.82	15	3.19	6	1.27
Sumter	129752	2	1.54	2	1.54	1	0.77
Suwannee	43474	1	2.30	1	2.30	2	4.60
Taylor	21796	2	9.18	5	22.94	1	4.59
Union	16147	1	6.19	1	6.19	2	12.39
Volusia	553543	35	6.32	25	4.52	21	3.79
Wakulla	33764	7	20.73	9	26.66	1	2.96
Walton	75305	2	2.66	2	2.66		
Washington	25318	1	3.95	0	0.00	1	3.95

Figure 3. Provider Density by Zip Code

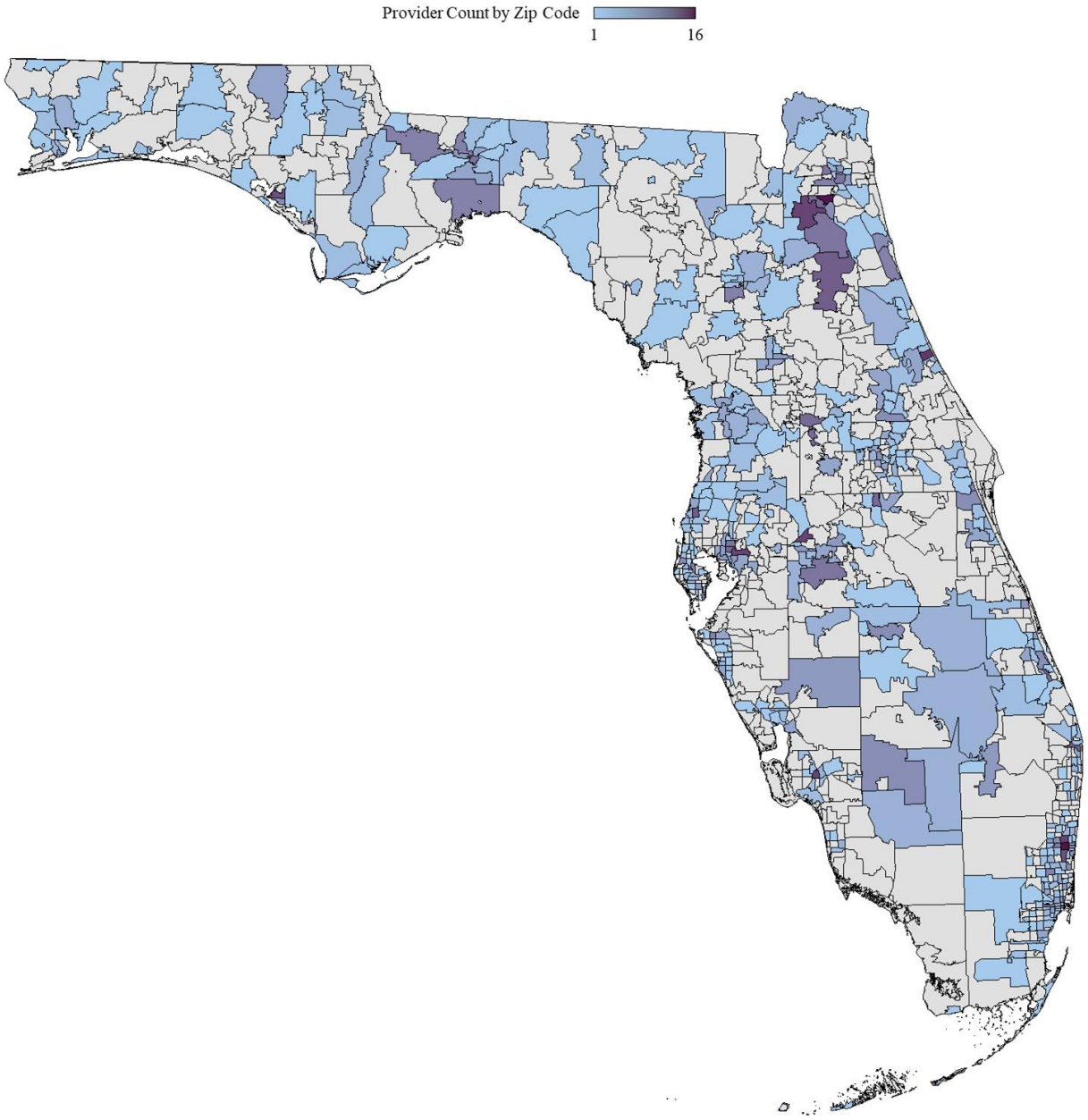


Table 7. FY24/25 Total Dollars Contracted by DCF for Each Community-Based Core Program Area Adult Mental Health (AMH) Service by Managing Entity (ME)

Total Dollars Contracted by DCF for Each Community-Based Adult Mental Health (AMH) Service	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	CFBHN	CFCHS	LSF	NFHN	SFBHN	SEFBHN
Aftercare							
Assessment	$509,753	$741,273	$130,639	$593,958	$393,004	$483,803	$305,834
Behavioral Health Network (BNET)							
Care Coordination	$850,000		$2	$15,468	$90,469	$300,000	$767,784
Case Management	$5,680,773	$8,577,514	$2,882,984	$3,792,978	$2,599,369	$3,927,779	$1,625,906
Central Receiving System				$2,719,456			$2,970,000
Community Action Team (CAT Team)			$10,001				
Comprehensive Community Service Team (CCST)						$907,477	$640,945
Cost Reimbursement				$8,454,046		$30,486	
Crisis Stabilization	$3,392,909	$26,211,176	$11,328,332	$16,449,058	$14,747,278	$8,575,691	$10,498,900
Crisis Support/Emergency	$1,150,156	$15,070,743	$5,341,151	$17,504,481	$6,717,663	$5,008,064	$804,126
Day Care				$193			
Day Treatment	$429,781	$490,802		$325,400	$450,510	$414,002	$775,478
Disaster Behavioral Health			$540,000				
Drop In/Self-Help Centers	$550,521	$1,452,115	$55,000	$1,070,440	$70,100	$737,023	$447,422
Family Intensive Treatment Team (FIT Team)					$361,666		
Federal Project Grant	$61,532		$1,092,006		$630,516		
First Episode Team			$5,000	$1,462,500	$375,000	$1,500,000	$1,599,450
Florida Assertive Community Treatment Team (FACT Team)	$883,401	$9,517,577	$2,184,013	$5,934,870	$3,391,354	$1,575,200	$2,320,495
Florida's Coordinated Opioid Recovery (CORE) Network of Addiction Care							
Forensic Local Diversion Project	$800,000						
Forensic Multidisciplinary Team	$652,000	$1,956,000		$3,260,000	$750,941	$669,380	$1,363,325

Total Dollars Contracted by DCF for Each Community-Based Adult Mental Health (AMH) Service	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	CFBHN	CFCHS	LSF	NFHN	SFBHN	SEFBHN
HIV Early Intervention Services							
Incidental Expenses	$2,329,485	$5,481,447	$851,045	$775,469	$277,154	$3,847,130	$2,975,287
Information and Referral	$385,573	$1,791,711		$1,228,665	$983,633	$1,515,433	$339,581
In-Home and On-Site	$371,954	$41,055	$137,396	$154,618	$53,532	$429,102	$66,610
Inpatient			$283,147	$1,839,281			
Intensive Case Management		$140,042	$130,000	$71,476			$690,849
Intervention	$601,820	$1,847,632	$27,840	$188,736		$1,024,694	$67,553
Local Forensic Diversion Project				$580,350			
Medical Services	$601,528	$6,283,221	$1,695,546	$2,308,316	$4,164,920	$2,546,360	$2,128,808
Medication Assisted Treatment							
Mental Health Clubhouse Services	$109,822	$2,883,262	$675,770	$931,941		$1,291,951	$300,000
Multidisciplinary Child Welfare Teams							
Network Evaluation & Development		$46,728	$3,453,021	$166,541		$82,500	$122,000
Opioid Settlement - Non-Qualified County (NQC)							
Other Bundled Projects	$656,500	$1,143,000	$977,267	$4,364,287	$1,014,155	$136,000	$4,098,068
Other Bundled Projects (Transitional Beds for MH Institution)				$1,622,236			
Other Multidisciplinary Team				$1,000,000			
Outpatient	$2,749,753	$2,811,927	$844,043	$1,777,766	$2,868,526	$2,521,539	$1,618,018
Outreach	$1,541,678	$2,628,424	$699,291	$1,188,456	$198,439	$1,891,925	$87,329
Prevention – Indicated	$385,563					$10,000	
Prevention – Selective	$385,563					$40,000	
Prevention - Universal Direct	$385,563					$113,222	
Prevention - Universal Indirect	$385,563					$103,778	
Provider Proviso Projects		$1,450,000	$500,000	$1,250,000	$243,675		$3,900,000
Recovery Support	$1,176,407	$140,435	$320,609	$246,731		$70,186	$700,898
Residential Level I	$2,418,202	$1,805,089				$281,429	$1,462,438

Total Dollars Contracted by DCF for Each Community-Based Adult Mental Health (AMH) Service	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	**CFBHN**	**CFCHS**	**LSF**	**NFHN**	**SFBHN**	**SEFBHN**
Residential Level II	$1,963,377	$2,924,481	$2,163,047	$4,164,701	$1,772,307	$11,912,573	$370,528
Residential Level III	$916,637	$80,436	$100		$1,404,150		$400,809
Residential Level IV	$950,427	$2,459,096	$248,050	$723,222	$295,000	$954,484	$1,702,859
Respite Services	$206,608			$329,144			$195,562
Room and Board with Supervision Level I	$428,916				$10,109,902		
Room and Board with Supervision Level II	$1,042,579	$5,702,458	$2,694,328	$4,356,422	$1,253,288	$2,310,034	$1,299,656
Room and Board with Supervision Level III	$2,519,470		$1,519,981	$1,439,729		$2,271,473	
Room and Board with Supervision Level IV				$81,970			
Self- Directed Care		$376,400					
Short-Term Residential Treatment	$1,725,952	$2,369,004	$3,772,190		$3,159,991	$2,813,832	$4,047,356
Start-Up Cost Reimbursement			$1,061,078		$1,123,192	$590,896	$89,822
Substance Abuse Inpatient Detoxification			$388,880	$393,476			
Substance Abuse Outpatient Detoxification							
Supported Employment	$476,984	$457,520		$320,826	$25,689	$54,010	$303,451
Supportive Housing/Living	$1,799,336	$3,628,638	$505,076	$574,619	$229,800	$73,300	$729,002
Treatment Alternative for Safer Communities (TASC)							
Wraparound			$740,000		$772,484		
Total Across All AMH Services	**$41,476,085**	**$110,509,206**	**$47,256,835**	**$93,661,828**	**$60,527,707**	**$61,014,756**	**$51,816,147**

Table 8. FY24/25 Total Dollars Contracted by DCF for Each Community-Based Core Program Area Adult Substance Abuse (ASA) Service by Managing Entity (ME)

Total Dollars Contracted by DCF for Each Community-Based Adult Substance Abuse (ASA) Service	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	CFBHN	CFCHS	LSF	NFHN	SFBHN	SEFBHN
Aftercare	$723,623	$29,000	$197,330	$26,177	$57,418	$31,889	$62,855
Assessment	$747,603	$350,314	$918,551	$607,170	$92,865	$358,655	$533,135
Behavioral Health Network (BNET)							
Care Coordination	$725,000		$460,000	$76,535	$1,255,245	$600,000	$482,741
Case Management	$1,826,163	$3,205,687	$1,939,379	$1,074,927	$1,939,689	$1,289,441	$705,600
Central Receiving System							
Community Action Team (CAT Team)							
Comprehensive Community Service Team (CCST)							$382,426
Cost Reimbursement							
Crisis Stabilization							
Crisis Support/Emergency	$1,064,242	$1,543,949	$1,351,471	$3,887,121	$630,885	$596,117	$257,850
Day Care		$49,130		$254,172			
Day Treatment	$104,050	$4,066	$211,999		$57,045	$834,337	$1,381,581
Disaster Behavioral Health							
Drop In/Self-Help Centers							
Family Intensive Treatment Team (FIT Team)	$800,000	$6,683,984	$1,241,932	$3,685,894	$2,057,668		$2,400,000
Federal Project Grant	$250,000		$111,231		$161,722	$42,500	$759,593
First Episode Team							
Florida Assertive Community Treatment Team (FACT Team)							
Florida's Coordinated Opioid Recovery (CORE) Network of Addiction Care				$5,193,857			
Forensic Local Diversion Project							
Forensic Multidisciplinary Team							

Total Dollars Contracted by DCF for Each Community-Based Adult Substance Abuse (ASA) Service	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	CFBHN	CFCHS	LSF	NFHN	SFBHN	SEFBHN
HIV Early Intervention Services	$332,347						$468,817
Incidental Expenses	$2,282,014	$2,320,420	$3,305,247	$319,223	$1,017,433	$341,672	$831,863
Information and Referral	$706,449	$328,482	$261,551	$335,255		$509,139	$257,850
In-Home and On-Site	$449,069					$2,047,803	$299,268
Inpatient							
Intensive Case Management							
Intervention	$611,452	$2,400,271	$1,821,513	$663,634	$190,974	$1,397,468	$65,304
Local Forensic Diversion Project							
Medical Services	$1,479,259	$3,752,265	$2,552,113	$599,316	$1,204,324	$212,030	$2,221,743
Medication Assisted Treatment	$4,544,595	$3,321,678	$977,232	$3,991,096	$95	$1,105,030	$5,154,726
Mental Health Clubhouse Services							
Multidisciplinary Child Welfare Teams		$400,000					
Network Evaluation & Development		$4,702,045	$377,807	$14,010	$2,506,097		$0
Opioid Settlement - Non-Qualified County (NQC)				$8,186,724			
Other Bundled Projects	$900,000		$410,000	$2,506,544	$1,971,660	$450,000	$540,261
Other Bundled Projects (Transitional Beds for MH Institution)							
Other Multidisciplinary Team							
Outpatient	$3,271,543	$2,694,650	$4,258,951	$766,838	$2,733,474	$1,628,482	$3,632,130
Outreach	$2,516,833	$2,408,867	$2,092,996	$2,153,500	$429,165	$449,179	$1,685,234
Prevention – Indicated	$117,849	$153,060	$264,091	$13,289	$802	$2,000	$37,500
Prevention – Selective	$46,000	$268,677	$121,600	$37,919	$268,699	$2,000	
Prevention - Universal Direct	$706,449	$156,685	$131,291	$152,834	$106,496	$2,000	$217,712
Prevention - Universal Indirect	$117,849	$664,979	$121,740	$547,184	$62,473	$155,678	$48,112
Provider Proviso Projects	$83,270		$500,000	$3,650,000			
Recovery Support	$2,371,559	$1,478,901	$3,871,254	$117,409	$125,909	$751,631	$1,844,910
Residential Level I	$700,000	$3,652,603	$1,652,632	$1,010,056			$199,293

Total Dollars Contracted by DCF for Each Community-Based Adult Substance Abuse (ASA) Service	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	**CFBHN**	**CFCHS**	**LSF**	**NFHN**	**SFBHN**	**SEFBHN**
Residential Level II	$7,346,300	$12,425,376	$6,838,481	$12,222,741	$7,176,927	$15,114,284	$5,564,776
Residential Level III	$477,619	$1,546,820	$535,807		$85,313	$1,072,983	$757,827
Residential Level IV	$40,458	$566,534	$587,911		$672,364	$1,184,504	$342,252
Respite Services	$900,000			$5,767			$28,753
Room and Board with Supervision Level I							
Room and Board with Supervision Level II	$185,516	$614,523	$200,000	$1,738,855	$487,250	$202,311	$232,546
Room and Board with Supervision Level III		$83,082		$208,555			$456,245
Room and Board with Supervision Level IV							
Self- Directed Care							
Short-Term Residential Treatment							
Start-Up Cost Reimbursement		$251,233	$2			$2,652,812	$2,658,247
Substance Abuse Inpatient Detoxification	$715,655	$10,606,942	$6,058,790	$8,619,267	$3,435,101	$1,862,946	$3,779,990
Substance Abuse Outpatient Detoxification	$750,000						
Supported Employment	$98,692						$20,690
Supportive Housing/Living	$100,607	$1,230,915	$20,000	$188,164			
Treatment Alternative for Safer Communities (TASC)			$320,000		$437		$525,159
Wraparound							
Total Across All ASA Services	**$38,092,065**	**$67,895,138**	**$43,712,901**	**$62,854,031**	**$28,727,528**	**$34,896,891**	**$38,836,989**

Table 9. FY24/25 Total Dollars Contracted by DCF for Each Community-Based Core Program Area Child Mental Health (CMH) Service by Managing Entity (ME)

Total Dollars Contracted by DCF for Each Community-Based Child Mental Health (CMH) Service	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	CFBHN	CFCHS	LSF	NFHN	SFBHN	SEFBHN
Aftercare							
Assessment	$64,317	$69,093	$103,396	$39,632	$3,000	$209,434	$219,346
Behavioral Health Network (BNET)	$656,925	$1,557,609	$1,091,606	$720,753	$251,864	$126,848	$442,978
Care Coordination	$650,000			$170,223	$618,051		$120,000
Case Management	$42,466	$2,007,002	$1,130,339	$375,688	$67,423	$378,304	$1,367,970
Central Receiving System					$1,749,000		
Community Action Team (CAT Team)	$25,486	$14,453,710	$4,531,191	$12,375,000	$8,055,002	$3,950,000	$2,687,257
Comprehensive Community Service Team (CCST)						$839,067	$76,287
Cost Reimbursement				$6,956,645			
Crisis Stabilization	$75,000	$2,951,884	$356,978	$2,063,692	$144,270	$1,100,000	$432,160
Crisis Support/Emergency	$1,381,598	$6,912,405	$890,026	$6,773,827	$237,297	$1,565,789	$804,126
Day Care							
Day Treatment	$5,000			$708,207			
Disaster Behavioral Health							
Drop In/Self-Help Centers							
Family Intensive Treatment Team (FIT Team)							
Federal Project Grant							
First Episode Team		$2,250,000	$5,000		$375,000		
Florida Assertive Community Treatment Team (FACT Team)							
Florida's Coordinated Opioid Recovery (CORE) Network of Addiction Care							
Forensic Local Diversion Project							
Forensic Multidisciplinary Team							

Total Dollars Contracted by DCF for Each Community-Based Child Mental Health (CMH) Service	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	CFBHN	CFCHS	LSF	NFHN	SFBHN	SEFBHN
HIV Early Intervention Services							
Incidental Expenses	$356,221	$66,305	$45,473	$222,881		$159,231	$50,979
Information and Referral	$6,502	$117,591		$4,000,786		$54,101	$284,581
In-Home and On-Site	$70,897	$189,732	$311,000	$17,913		$766,821	$76,610
Inpatient	$64,202		$19,800				
Intensive Case Management				$181,915			$744,142
Intervention	$607,869	$1,096	$360,500	$290,338	$716,300	$262,250	$87,663
Local Forensic Diversion Project							
Medical Services	$42,273	$344,488	$19,902	$126,752	$28,000	$161,800	$1,417,049
Medication Assisted Treatment							
Mental Health Clubhouse Services							
Multidisciplinary Child Welfare Teams		$358,712					
Network Evaluation & Development			$500,000				$54,650
Opioid Settlement - Non-Qualified County (NQC)							
Other Bundled Projects	$619,723	$193,000	$3,455,727	$7,823,758	$2,325,242	$4,493,151	$450,000
Other Bundled Projects (Transitional Beds for MH Institution)							
Other Multidisciplinary Team							
Outpatient	$206,973	$880,883	$123,711	$298,280	$575,480	$242,215	$1,579,206
Outreach	$1,116,139	$254,236	$350,000	$171,660	$1,000	$184,150	$124,312
Prevention – Indicated	$1,210						
Prevention – Selective	$605						
Prevention - Universal Direct	$605						$74,000
Prevention - Universal Indirect	$605						
Provider Proviso Projects	$660,000	$670,000		$1,050,000	$1,014,243		$742,700
Recovery Support	$29,535		$50,000	$5,416		$2,000	$71,902
Residential Level I	$10,000	$1,296,500				$175,000	$0

Total Dollars Contracted by DCF for Each Community-Based Child Mental Health (CMH) Service	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	**CFBHN**	**CFCHS**	**LSF**	**NFHN**	**SFBHN**	**SEFBHN**
Residential Level II							$0
Residential Level III							
Residential Level IV							
Respite Services	$307,500		$1,000				$156,947
Room and Board with Supervision Level I			$19,800				
Room and Board with Supervision Level II			$53,567	$235,194			$0
Room and Board with Supervision Level III							
Room and Board with Supervision Level IV							
Self- Directed Care							
Short-Term Residential Treatment						$2,592,960	
Start-Up Cost Reimbursement			$1		$1,000	$30,486	$135,665
Substance Abuse Inpatient Detoxification							
Substance Abuse Outpatient Detoxification							
Supported Employment	$8,000						
Supportive Housing/Living	$165,083						$626,654
Treatment Alternative for Safer Communities (TASC)							
Wraparound				$248,504			
Total Across All CMH Services	**$7,174,732**	**$34,574,246**	**$13,419,018**	**$44,857,065**	**$16,162,171**	**$17,293,607**	**$12,827,183**

Table 10. FY24/25 Total Dollars Contracted by DCF for Each Community-Based Core Program Area Child Substance Abuse (CSA) Service by Managing Entity (ME)

Total Dollars Contracted by DCF for Each Community-Based Child Substance Abuse (CSA) Service	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	CFBHN	CFCHS	LSF	NFHN	SFBHN	SEFBHN
Aftercare	$58,321	$980					
Assessment	$11,185	$25,049	$90,403	$62,798	$11,712	$266,344	
Behavioral Health Network (BNET)							
Care Coordination							$60,000
Case Management	$15,800	$205,572	$50,000	$18,076	$35,935	$214,000	$5,828
Central Receiving System							
Community Action Team (CAT Team)							
Comprehensive Community Service Team (CCST)						$146,773	
Cost Reimbursement				$110,255			
Crisis Stabilization							
Crisis Support/Emergency	$853,535	$1,254,490		$1,058,822	$630,885	$105,000	$77,850
Day Care							
Day Treatment	$700						
Disaster Behavioral Health							
Drop In/Self-Help Centers							
Family Intensive Treatment Team (FIT Team)					$361,666		
Federal Project Grant					$99,352		
First Episode Team							
Florida Assertive Community Treatment Team (FACT Team)							
Florida's Coordinated Opioid Recovery (CORE) Network of Addiction Care							
Forensic Local Diversion Project							
Forensic Multidisciplinary Team							

Total Dollars Contracted by DCF for Each Community-Based Child Substance Abuse (CSA) Service	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	CFBHN	CFCHS	LSF	NFHN	SFBHN	SEFBHN
HIV Early Intervention Services	$50						$49,092
Incidental Expenses	$31,744	$28,490	$41,140				$120
Information and Referral	$1,197,554	$494,028		$289,876		$188,852	$77,850
In-Home and On-Site	$15,744	$11,748		$4,857		$2,860,264	$299,268
Inpatient							
Intensive Case Management							
Intervention	$40,002	$1,380,675	$545,336	$267,644	$104,162	$261,040	
Local Forensic Diversion Project							
Medical Services	$800	$263,660	$42,344	$45,886	$10,542	$7,000	$2,802
Medication Assisted Treatment							
Mental Health Clubhouse Services							
Multidisciplinary Child Welfare Teams							
Network Evaluation & Development						$544,000	
Opioid Settlement - Non-Qualified County (NQC)				$246,879			
Other Bundled Projects		$300,000		$96,810	$482,784		$216,000
Other Bundled Projects (Transitional Beds for MH Institution)							
Other Multidisciplinary Team							
Outpatient	$484,958	$167,799	$136,200	$41,278	$525,482	$33,573	$201,097
Outreach	$125,551	$961,406	$50,000	$258,985	$3,331	$311,976	$725,549
Prevention – Indicated	$65,000	$576,915	$1,074,368	$195,547	$219,253	$751,636	$80,923
Prevention – Selective	$173,000	$1,481,258	$1,117,049	$7,851	$1,012,248	$1,931,499	
Prevention - Universal Direct	$897,554	$2,742,407	$1,269,232	$2,003,066	$1,082,195	$794,611	$2,696,122
Prevention - Universal Indirect	$65,000	$1,381,941	$1,675,440	$2,579,302		$802,074	$517,511
Provider Proviso Projects							
Recovery Support	$15,300	$16,644				$5,000	$11,656
Residential Level I			$50,000				

Total Dollars Contracted by DCF for Each Community-Based Child Substance Abuse (CSA) Service	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	**CFBHN**	**CFCHS**	**LSF**	**NFHN**	**SFBHN**	**SEFBHN**
Residential Level II	$35,000	$430,163	$960,375	$2,938,194		$610,594	$2,162,331
Residential Level III							
Residential Level IV		$28,384					
Respite Services							
Room and Board with Supervision Level I							
Room and Board with Supervision Level II			$530,000	$361,580			
Room and Board with Supervision Level III							
Room and Board with Supervision Level IV							
Self- Directed Care							
Short-Term Residential Treatment							
Start-Up Cost Reimbursement						$30,000	
Substance Abuse Inpatient Detoxification	$133,321	$1,067,494	$204,613			$902,547	
Substance Abuse Outpatient Detoxification							
Supported Employment	$12,500						
Supportive Housing/Living	$14,000						
Treatment Alternative for Safer Communities (TASC)			$961,494	$71,926	$31,893	$51,586	$525,159
Wraparound							
Total Across All CSA Services	**$4,246,619**	**$12,819,103**	**$8,797,996**	**$10,659,630**	**$4,611,440**	**$10,818,369**	**$7,709,159**

Table 11. Florida SMHA Expenditures by Setting

STRUCTURE DOMAIN: State Mental Health Agency Controlled Expenditures for Mental Health, FY 2024

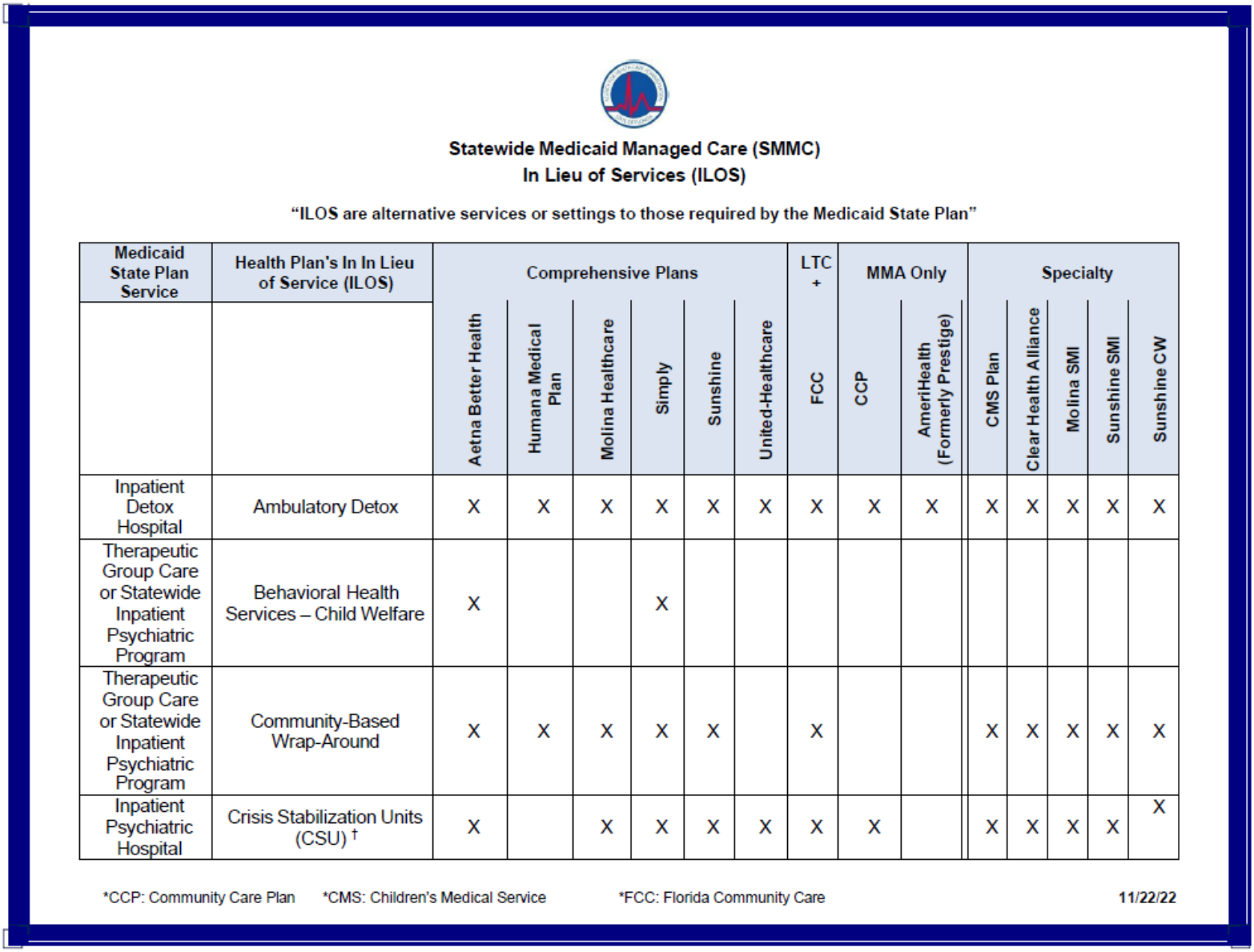
Florida **Reporting Period:** 7/1/2023 To: 6/30/2024

Activity	Expenditures: State	Percent of Total Expenditures: State	Expenditures: US	Percent of Total Expenditures: US	States Reporting
Mental Health Prevention	$8,109,964	1%	$163,727,206	0%	22
EBPs for Early Serious Mental Illness Including First Episode Psychosis	$10,773,142	1%	$191,488,797	0%	58
State Hospitals	$580,767,400	48%	$14,831,238,700	24%	56
Other Psychiatric Inpatient Care	-	0%	$1,562,508,766	3%	18
Other 24-Hour Care	$29,055,184	2%	$6,206,395,177	10%	48
Ambulatory/Community	$498,345,684	41%	$34,591,900,760	56%	58
Crisis Services	$49,108,168	4%	$2,187,373,082	4%	57
Administration	$43,920,625	4%	$1,559,005,405	3%	57
Total	**$1,220,080,166**	**100%**	**$61,293,637,894**	**100%**	**58**

Notes:

This table uses data from URS Table 7A.

Figure 4. AHCA ILOS Chart



Statewide Medicaid Managed Care (SMMC)
In Lieu of Services (ILOS)

"ILOS are alternative services or settings to those required by the Medicaid State Plan"

Medicaid State Plan Service	Health Plan's In In Lieu of Service (ILOS)	Comprehensive Plans						LTC +	MMA Only		Specialty				
		Aetna Better Health	Humana Medical Plan	Molina Healthcare	Simply	Sunshine	United-Healthcare	FCC	CCP	AmeriHealth (Formerly Prestige)	CMS Plan	Clear Health Alliance	Molina SMI	Sunshine SMI	Sunshine CW
Inpatient Detox Hospital	Ambulatory Detox	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Therapeutic Group Care or Statewide Inpatient Psychiatric Program	Behavioral Health Services – Child Welfare	X			X										
Therapeutic Group Care or Statewide Inpatient Psychiatric Program	Community-Based Wrap-Around	X	X	X	X	X		X			X	X	X	X	X
Inpatient Psychiatric Hospital	Crisis Stabilization Units (CSU) †	X		X	X	X	X	X	X		X	X	X	X	X

*CCP: Community Care Plan *CMS: Children's Medical Service *FCC: Florida Community Care 11/22/22

Medicaid State Plan Service	Health Plan's In In Lieu of Service (ILOS)	Comprehensive Plans						LTC +	MMA Only		Specialty				
		Aetna Better Health	Humana Medical Plan	Molina Healthcare	Simply	Sunshine	United-Healthcare	FCC	CCP	AmeriHealth (Formerly Prestige)	CMS Plan	Clear Health Alliance	Molina SMI	Sunshine SMI	Sunshine CW
Inpatient Detox Hospital	Detox or Addictions Receiving Facilities †	X	X	X	X	X	X	X	X		X	X	X	X	X
Clubhouse	Drop-in Center	X	X	X	X	X		X			X	X	X	X	X
Therapeutic Behavioral On-site (TBOS)	Family Training/Counseling for Child Development	X	X	X	X	X					X	X	X	X	X
Inpatient Psychiatric Hospital	Specialty Psychiatric Hospitals †	X	X	X	X	X	X	X	X		X	X	X	X	X
Psychological Testing	Infant Mental Health Pre and Post Testing	X	X	X	X	X					X	X	X	X	X
Inpatient Hospital	Intensive Outpatient Mental Health					X					X			X	X
Inpatient Psychiatric Hospital Care	Mental Health Partial Hospitalization Program (PHP)	X	X	X	X	X		X	X		X		X	X	X
Emergency Behavioral Health	Mobile Crisis Assessment/Intervention	X	X	X	X	X	X	X		X	X	X	X	X	X

Medicaid State Plan Service	Health Plan's In In Lieu of Service (ILOS)	Comprehensive Plans						LTC +	MMA Only		Specialty				
		Aetna Better Health	Humana Medical Plan	Molina Healthcare	Simply	Sunshine	United-Healthcare	FCC	CCP	AmeriHealth (Formerly Prestige)	CMS Plan	Clear Health Alliance	Molina SMI	Sunshine SMI	Sunshine CW
Inpatient and Residential Stay or Statewide Inpatient Psychiatric Program	Multi Systemic Therapy					X					X			X	X
Inpatient Hospital	Nursing Facility †	X		X	X	X	X	X	X	X	X	X	X	X	X
Inpatient Psychiatric Care	Partial Hospitalization in a Hospital	X	X	X	X	X	X	X		X	X	X	X	X	X
Psychosocial Rehab	Self-help/Peer Services	X	X	X	X	X	X	X		X	X	X	X	X	X
Inpatient Detoxification Hospital Care	Substance Abuse Intensive Outpatient Program (IOP)	X	X	X	X	X	X	X			X	X	X	X	X
Inpatient Detoxification Hospital Care	Substance Abuse Short-term Residential Treatment (SRT)	X	X	X	X	X	X	X			X	X	X	X	X

† Plans may provide this in lieu of service without any Agency approval. All other in lieu of services provided by the plan require Agency approval.

Table 12. FY24/25 DCF Cost Management Strategies Utilized to Fund Community-Based Core Program Area Adult Mental Health (AMH) Services by Managing Entity (ME)

DCF Cost Management Strategies[1] Utilized to Fund Community-Based Adult Mental Health (AMH) Services	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	CFBHN	CFCHS	LSF	NFHN	SFBHN	SEFBHN
Aftercare							
Assessment	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Behavioral Health Network (BNET)							
Care Coordination	FFS		CR	FFS	FFS	FFS	FFS
Case Management	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Central Receiving System				Cap			FFS
Community Action Team (CAT Team)			CR / FFS				
Comprehensive Community Service Team (CCST)						FFS	FFS
Cost Reimbursement				CR		CR	
Crisis Stabilization	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Crisis Support/Emergency	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Day Care				FFS			
Day Treatment	FFS	FFS		FFS	FFS	FFS	FFS
Disaster Behavioral Health			FFS				
Drop In/Self-Help Centers	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Family Intensive Treatment Team (FIT Team)					CR		
Federal Project Grant	FFS		Cap		FFS		
First Episode Team			FFS	Cap	FFS	FFS	FFS
Florida Assertive Community Treatment Team (FACT Team)	CR	FFS	CR	CR	Cap	Cap / FFS	FFS
Florida's Coordinated Opioid Recovery (CORE) Network of Addiction Care							
Forensic Local Diversion Project	FFS						
Forensic Multidisciplinary Team	Cap	FFS		Cap / CR	CR / FFS	Cap	Cap
HIV Early Intervention Services							
Incidental Expenses	CR / FFS	FFS	FFS	CR	FFS	FFS	CR
Information and Referral	FFS	FFS		FFS	FFS	FFS	FFS
In-Home and On-Site	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Inpatient			FFS	FFS			
Intensive Case Management		FFS	FFS	FFS			FFS
Intervention	FFS	FFS	FFS	FFS		FFS	FFS
Local Forensic Diversion Project				Cap			

Medical Services	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Medication Assisted Treatment							
Mental Health Clubhouse Services	FFS	FFS	FFS	FFS		FFS	FFS
Multidisciplinary Child Welfare Teams							
Network Evaluation & Development		FFS	CR / FFS	CR		FFS	CR / FFS
Opioid Settlement - Non-Qualified County (NQC)							
Other Bundled Projects	FFS	CR / FFS	FFS	Cap / CR	CR / FFS	FFS	FFS
Other Bundled Projects (Transitional Beds for MH Institution)				Cap			
Other Multidisciplinary Team				Cap			
Outpatient	FFS	FFS	FFS	Cap	FFS	FFS	FFS
Outreach	FFS	FFS	FFS	Cap	FFS	FFS	FFS
Prevention - Indicated	FFS					FFS	
Prevention - Selective	FFS					FFS	
Prevention - Universal Direct	FFS					FFS	
Prevention - Universal Indirect	FFS					FFS	
Provider Proviso Projects		CR	FFS	Cap	CR		FFS
Recovery Support	FFS	FFS	FFS	FFS		FFS	FFS
Residential Level I	Cap / FFS	FFS				FFS	FFS
Residential Level II	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Residential Level III	FFS	FFS	FFS		FFS		FFS
Residential Level IV	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Respite Services	FFS			FFS			FFS
Room and Board with Supervision Level I	FFS				FFS		
Room and Board with Supervision Level II	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Room and Board with Supervision Level III	FFS		FFS	FFS		FFS	
Room and Board with Supervision Level IV				FFS			
Self- Directed Care		FFS					
Short-Term Residential Treatment	FFS	FFS	FFS		FFS	FFS	FFS
Start-Up Cost Reimbursement			CR		CR	CR / FFS	CR
Substance Abuse Inpatient Detoxification			FFS	FFS			
Substance Abuse Outpatient Detoxification							
Supported Employment	FFS	FFS		FFS	FFS	FFS	FFS
Supportive Housing/Living	FFS	FFS	FFS	CR / FFS	FFS	FFS	FFS
Treatment Alternative for Safer Communities (TASC)							
Wraparound			FFS		FFS		

Table 13. FY24/25 DCF Cost Management Strategies Utilized to Fund Community-Based Core Program Area Adult Substance Abuse (ASA) Services by Managing Entity (ME)

DCF Cost Management Strategies[1] Utilized to Fund Community-Based Adult Substance Abuse (ASA) Services	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	CFBHN	CFCHS	LSF	NFHN	SFBHN	SEFBHN
Aftercare	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Assessment	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Behavioral Health Network (BNET)							
Care Coordination	FFS		CR / FFS	FFS	FFS	FFS	FFS
Case Management	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Central Receiving System							
Community Action Team (CAT Team)							
Comprehensive Community Service Team (CCST)							FFS
Cost Reimbursement							
Crisis Stabilization							
Crisis Support/Emergency	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Day Care		FFS		FFS			
Day Treatment	FFS	FFS	FFS		FFS	FFS	FFS
Disaster Behavioral Health							
Drop In/Self-Help Centers							
Family Intensive Treatment Team (FIT Team)	Cap	FFS	FFS	Cap	CR		FFS
Federal Project Grant	FFS		FFS		FFS	FFS	CR / FFS
First Episode Team							
Florida Assertive Community Treatment Team (FACT Team)							
Florida's Coordinated Opioid Recovery (CORE) Network of Addiction Care				Cap			
Forensic Local Diversion Project							
Forensic Multidisciplinary Team							
HIV Early Intervention Services	FFS						FFS
Incidental Expenses	Cap / CR / FFS	FFS	FFS	CR	FFS	FFS	CR
Information and Referral	FFS	FFS	FFS	FFS		FFS	FFS
In-Home and On-Site	FFS					FFS	FFS
Inpatient							
Intensive Case Management							

Intervention	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Local Forensic Diversion Project							
Medical Services	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Medication Assisted Treatment	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Mental Health Clubhouse Services							
Multidisciplinary Child Welfare Teams		FFS					
Network Evaluation & Development		CR / FFS	CR / CR	CR	FFS		FFS
Opioid Settlement - Non-Qualified County (NQC)				Cap			
Other Bundled Projects	CR		FFS	Cap	FFS	FFS	FFS
Other Bundled Projects (Transitional Beds for MH Institution)							
Other Multidisciplinary Team							
Outpatient	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Outreach	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Prevention - Indicated	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Prevention - Selective	FFS	FFS	FFS	FFS	FFS	FFS	
Prevention - Universal Direct	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Prevention - Universal Indirect	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Provider Proviso Projects	CR		CR	Cap			
Recovery Support	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Residential Level I	FFS	FFS	FFS	FFS			FFS
Residential Level II	Cap / FFS	FFS	FFS	FFS	FFS	FFS	FFS
Residential Level III	FFS	FFS	FFS		FFS	FFS	FFS
Residential Level IV	FFS	FFS	FFS		FFS	FFS	FFS
Respite Services	FFS			FFS			FFS
Room and Board with Supervision Level I							
Room and Board with Supervision Level II	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Room and Board with Supervision Level III		FFS		FFS			FFS
Room and Board with Supervision Level IV							
Self- Directed Care							
Short-Term Residential Treatment							
Start-Up Cost Reimbursement		CR	CR			CR	CR
Substance Abuse Inpatient Detoxification	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Substance Abuse Outpatient Detoxification	FFS						
Supported Employment	FFS						FFS
Supportive Housing/Living	FFS	FFS	FFS	FFS			

Treatment Alternative for Safer Communities (TASC)			FFS		FFS		FFS
Wraparound							

Table 14. FY24/25 DCF Cost Management Strategies Utilized to Fund Community-Based Core Program Area Child Mental Health (CMH) Services by Managing Entity (ME)

DCF Cost Management Strategies[1] Utilized to Fund Community-Based Child Mental Health (CMH) Services	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	CFBHN	CFCHS	LSF	NFHN	SFBHN	SEFBHN
Aftercare							
Assessment	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Behavioral Health Network (BNET)	Cap	FFS	Cap	CR	Cap	Cap	Cap
Care Coordination	FFS			FFS	FFS		FFS
Case Management	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Central Receiving System					FFS		
Community Action Team (CAT Team)	FFS	FFS	FFS	Cap	CR	Cap / FFS	FFS
Comprehensive Community Service Team (CCST)						FFS	FFS
Cost Reimbursement				CR			
Crisis Stabilization	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Crisis Support/Emergency	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Day Care							
Day Treatment	FFS			FFS			
Disaster Behavioral Health							
Drop In/Self-Help Centers							
Family Intensive Treatment Team (FIT Team)							
Federal Project Grant							
First Episode Team		FFS	FFS		FFS		
Florida Assertive Community Treatment Team (FACT Team)							
Florida's Coordinated Opioid Recovery (CORE) Network of Addiction Care							
Forensic Local Diversion Project							
Forensic Multidisciplinary Team							
HIV Early Intervention Services							
Incidental Expenses	FFS	FFS	FFS	CR		FFS	CR
Information and Referral	FFS	FFS		FFS		FFS	FFS
In-Home and On-Site	FFS	FFS	FFS	FFS		FFS	FFS
Inpatient	FFS		FFS				
Intensive Case Management				FFS			FFS
Intervention	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Local Forensic Diversion Project							

Medical Services	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Medication Assisted Treatment							
Mental Health Clubhouse Services							
Multidisciplinary Child Welfare Teams		FFS					
Network Evaluation & Development			FFS				CR
Opioid Settlement - Non-Qualified County (NQC)							
Other Bundled Projects	FFS	FFS	FFS	Cap	CR / FFS	FFS	FFS
Other Bundled Projects (Transitional Beds for MH Institution)							
Other Multidisciplinary Team							
Outpatient	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Outreach	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Prevention - Indicated	FFS						
Prevention - Selective	FFS						
Prevention - Universal Direct	FFS						FFS
Prevention - Universal Indirect	FFS						
Provider Proviso Projects	CR / FFS	CR		Cap	CR		FFS
Recovery Support	FFS		FFS	FFS		FFS	FFS
Residential Level I	FFS	FFS				FFS	FFS
Residential Level II							FFS
Residential Level III							
Residential Level IV							
Respite Services	FFS		FFS				FFS
Room and Board with Supervision Level I			FFS				
Room and Board with Supervision Level II			FFS	FFS			FFS
Room and Board with Supervision Level III							
Room and Board with Supervision Level IV							
Self- Directed Care							
Short-Term Residential Treatment						FFS	
Start-Up Cost Reimbursement			CR		CR	CR	CR
Substance Abuse Inpatient Detoxification							
Substance Abuse Outpatient Detoxification							
Supported Employment	FFS						
Supportive Housing/Living	FFS						FFS
Treatment Alternative for Safer Communities (TASC)							

Wraparound				CR			

Table 15. FY24/25 DCF Cost Management Strategies Utilized to Fund Community-Based Core Program Child Substance Abuse (CSA) Services by Managing Entity (ME)

DCF Cost Management Strategies[1] Utilized to Fund Community-Based Child Substance Abuse (CSA) Services	Florida Department of Children and Families (DCF) Regional Managing Entities (MEs)						
	BBHC	CFBHN	CFCHS	LSF	NFHN	SFBHN	SEFBHN
Aftercare	FFS	FFS					
Assessment	FFS	FFS	FFS	FFS	FFS	FFS	
Behavioral Health Network (BNET)							
Care Coordination							FFS
Case Management	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Central Receiving System							
Community Action Team (CAT Team)							
Comprehensive Community Service Team (CCST)						FFS	
Cost Reimbursement				CR			
Crisis Stabilization							
Crisis Support/Emergency	FFS	FFS		FFS	FFS	FFS	FFS
Day Care							
Day Treatment	FFS						
Disaster Behavioral Health							
Drop In/Self-Help Centers							
Family Intensive Treatment Team (FIT Team)					CR		
Federal Project Grant					FFS		
First Episode Team							
Florida Assertive Community Treatment Team (FACT Team)							
Florida's Coordinated Opioid Recovery (CORE) Network of Addiction Care							
Forensic Local Diversion Project							
Forensic Multidisciplinary Team							
HIV Early Intervention Services	FFS						FFS
Incidental Expenses	FFS	FFS	FFS				CR
Information and Referral	FFS	FFS		FFS		FFS	FFS
In-Home and On-Site	FFS	FFS		FFS		FFS	FFS
Inpatient							
Intensive Case Management							
Intervention	FFS	FFS	FFS	FFS	FFS	FFS	
Local Forensic Diversion Project							

Medical Services	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Medication Assisted Treatment							
Mental Health Clubhouse Services							
Multidisciplinary Child Welfare Teams							
Network Evaluation & Development						FFS	
Opioid Settlement - Non-Qualified County (NQC)				Cap			
Other Bundled Projects		FFS		Cap	FFS		FFS
Other Bundled Projects (Transitional Beds for MH Institution)							
Other Multidisciplinary Team							
Outpatient	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Outreach	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Prevention - Indicated	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Prevention - Selective	FFS	FFS	FFS	FFS	FFS	FFS	
Prevention - Universal Direct	FFS	FFS	FFS	FFS	FFS	FFS	FFS
Prevention - Universal Indirect	FFS	FFS	FFS	FFS		FFS	FFS
Provider Proviso Projects							
Recovery Support	FFS	FFS				FFS	FFS
Residential Level I			FFS				
Residential Level II	FFS	FFS	FFS	FFS		FFS	FFS
Residential Level III							
Residential Level IV		FFS					
Respite Services							
Room and Board with Supervision Level I							
Room and Board with Supervision Level II			FFS	FFS			
Room and Board with Supervision Level III							
Room and Board with Supervision Level IV							
Self- Directed Care							
Short-Term Residential Treatment							
Start-Up Cost Reimbursement						CR	
Substance Abuse Inpatient Detoxification	FFS	A / FFS	FFS			FFS	
Substance Abuse Outpatient Detoxification							
Supported Employment	FFS						
Supportive Housing/Living	FFS						
Treatment Alternative for Safer Communities (TASC)			FFS	FFS	FFS	FFS	FFS
Wraparound							

Table 16. Financial and quality analysis processes for public and behavioral health systems tools.

Title	Reference	Link
A Self-Assessment and Planning Guide: Developing a Comprehensive Financing Plan	Armstrong et al. (2006)	A Self-Assessment and Planning Guide
Effective financing strategies for systems of care: Examples from the field—A resource compendium for financing systems of care	Stroul et al., (2009)	Effective Financing Strategies for Systems of Care
Healthcare Quality Management: A Case Study Approach	Pruitt et al., (2020)	Healthcare Quality Management

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