Florida Department of Children and Families

Behavioral Health Managing Entities (ME) Financial and Operational Audit Report

Recommendations included in this document should not be construed as legal advice.

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Executive Summary

Background & Overview

Ernst & Young LLP (EY) was engaged by the Florida Department of Children and Families ("DCF" or "Department") to perform financial and operational audits[1] of the seven regional Behavioral Health Managing Entities (MEs) responsible for overseeing the delivery of safety-net substance abuse and mental health services for individuals who are uninsured or underinsured. EY assessed the MEs' performance against the key financial and operational obligations outlined in House Bill (HB) 633 and the Department's contractual performance requirements[2]. HB 633 requires the Department to measure and report the MEs' financial and operational performance and issue a report of findings to the Governor and the Florida Legislature by December 1, 2025.

The audits were executed across all seven MEs concurrently to drive efficiency and timeliness, with key findings and recommendations for improvement summarized in this report. The audit results are outlined at both a summary and individual ME level to allow for:

- Comparison and consistent evaluation of financial and operational performance across the seven MEs
- Additional transparency into the MEs' business practices, with highlights of commendable practices (where applicable) at each ME, in addition to the findings and recommendations for improvement
- An objective third party assessment of the strength of the overall control environment within each ME, using a risk-based approach to identify unmitigated financial, operational, technology, and compliance risks

In addition to this report that summarizes the overall audit results, the findings and recommendations specific to each ME have been documented in seven individual reports that have been provided to the ME Leadership.

Audit Scope & Objectives

The audit covered fiscal years (FY) 2023-2024 and FY 2024-2025, as required by the legislation, and included evaluation of the MEs' processes and controls across key financial and operational domains as summarized in Table 1:

Table 1: In-Scope Financial and Operational Domains

Financial Domains	Funding allocation
	Expenditure allowability and tracking
	ME vs. Medicaid funding
	Financial contract requirements compliance
	Maintenance of financial records
	Financial internal control environment
Operational Domains	Governance and oversight
	Standard operating procedures
	Service delivery (access, grievances, referrals)
	Vendor/ sub-contractor management
	Adherence to contract performance outcomes
	Data platform adoption and utilization
	Operational internal control environment

[1] Please note that the term "audit" as used throughout this report refers to the financial and operational assessments conducted to evaluate the integrity of the MEs processes and controls. This report provides findings and recommendations for improvement but does not attest to or express an opinion on ME financial and operational results.
[2] Given that the effective date of HB 633 was subsequent to the defined audit period, testing results associated with HB 633 requirements were listed as "out of period observations" instead of findings.

The audit involved examination of financial records and practices, evaluation of contract compliance, as well as review of processes in place to monitor and report service delivery outcomes across the seven MEs. The financial and operational audit procedures were guided by defined audit objectives aligned to the key financial and operational requirements in HB 633 and the strategic oversight responsibilities laid out in the contracts between the Department and each ME.

It should be noted that even though the new requirements from HB 633 were not effective within the FY 2023-2024 and FY 2024-2025 audit period, it was essential for the auditors to perform additional audit work during FY 2025-2026 when the HB 633 requirements became effective to identify potential gaps in key areas such as referrals and newly established performance measures. While these new requirements are technically applicable outside of the audit period defined in the legislation, the audit work was done to gain insight into the current status of ME compliance with key HB 633 requirements at the time of the audit providing early warning signals of operational and financial areas where processes may require adjustment to align with HB 633 requirements. Recommended timeline and details regarding audit follow-up procedures are outlined within the "Audit Approach" section below.

The financial and operational audit objectives used to guide the audit procedures are outlined in Table 2. These audit objectives are intended to provide a summary view of how the audit scope was broken down across the in-scope operational financial and operational domains.

Table 2: Financial and Operational Audit Objectives

Financial	1	**Financial Audit Objective 1: Evaluate Financial Oversight and Governance** – assess the governance structures and financial processes (e.g., processes related to financial records maintenance and related parties) in place to measure the MEs' compliance with contractual and regulatory requirements.
	2	**Financial Audit Objective 2: Determine Soundness of Payment Methodology** – analyze the payment methodologies, funding allocations, and expense tracking mechanisms for efficacy and effectiveness.
	3	**Financial Audit Objective 3: Efficiency and Effectiveness of Expenditure Controls** – evaluate the controls used to measure expenditures against outcomes, including assessment of controls used to determine the appropriateness of the Department program funding vs. other sources of funding, such as Medicaid.
	4	**Financial Audit Objective 4: Quality of Services Provided Against Outcomes** – conduct comparative analysis of service delivery quality, outcomes, and key financial data across the MEs to test for completeness and accuracy and to identify recommendations for improvement.
Operational	1	**Operational Audit Objective 1: Evaluate Operational Oversight and Governance** – assess the governance frameworks and operational processes (e.g., executive compensation and personnel practices) of the MEs to ensure accountability and compliance with applicable requirements, policies, and standards.
	2	**Operational Audit Objective 2: Assess the Efficiency of Service Delivery** – analyze the business practices used for service administration to identify potential opportunities to enhance service delivery and accessibility.
	3	**Operational Audit Objective 3: Test the Efficacy of Operations** – examine the effectiveness of internal controls and operational processes (e.g., referral and grievance tracking mechanisms) to determine if they are functioning as intended and comply with established guidelines.
	4	**Operational Audit Objective 4: Review the Effectiveness of Data Utilization and Reporting** – review performance against HB 633 client outcome measures, evaluate the use of data platforms, and test the completeness and accuracy of reporting.

Audit Approach
The audit approach consisted of procedures designed to achieve an efficient and timely audit of the key financial, operational and compliance processes at each of the seven MEs. EY conducted the audits in accordance with the Institute of Internal Auditors (IIA) Professional Practice Standards and the American Institute of Certified Public Accountants (AICPA) Consulting Standards.

Operational and financial processes selected for detailed evaluation were determined using a risk-based prioritization approach, and audit test strategies were tailored to evaluate the design and operating effectiveness of the MEs' processes and controls used to maintain compliance with HB 633 and the Department's requirements. Our audit testing methods included the following:

- **Inquiry –** conducted interviews and asked questions of ME personnel to further understand and gather information about operational and/ or financial processes and controls.
- **Inspection –** examined ME and Department records, to verify accuracy, and completeness against "source of truth" documents.
- **Observation –** watched ME personnel execute processes and procedures to gain further understanding of the financial and operational processes. Observations took place during onsite walkthrough meetings where EY retained certain documents as audit evidence.
- **Recalculation –** this was primarily done to test the mathematical accuracy of documents, such as invoices, expense reports, reconciliations, or general ledger entries.
- **Reperformance –** in certain instances, EY independently executed a process or control procedure to verify whether the outcomes aligned with the ME-generated outcomes.

Depending on the financial or operational area being reviewed, and the attributes being verified against source documentation, one or more of the five audit methods noted above may have been leveraged to execute individual audit tests.

There were two main types of audit tests performed during the audit:

1. **Control tests** – key controls were identified through the review of policy and procedure documentation, interviews with ME leadership, inspection of source documentation, and observation of the execution of key operational and financial procedures. Controls are defined as activities that are designed to either prevent or detect and correct the occurrence of an adverse event. Effectively designed controls for key financial and operational processes were tested on a sample basis. The sampling method used was based on applicable professional standards. The number of units included in the sample for each audit test was based on the control frequency (annually, bi-annually, quarterly, monthly, etc.) and the criticality of the risk(s) being mitigated. Control testing sample selections were made randomly (using an automated randomizer), through targeted sampling based on professional judgement, or through non-statistical sampling without a defined criterion to avoid conscious bias. See Table 3 below for control testing sampling approach developed specifically for this audit. In instances where there were control gaps (i.e., poorly designed or absent control activities), these control gaps were noted as findings.
2. **Population/ transaction/ substantive tests** – rather than testing control activities, the performance of testing across an entire population of data or a defined subset of a population was conducted in instances where the audit tests involved evaluating the completeness and accuracy of data, comparison of multiple data sets to perform reconciliations, reasonableness tests, and to identify trends. The number of population tests that could be performed during this audit was limited due to either the unavailability of data needed to perform the required tests and/ or populations with required attributes for testing were related to FY 2025-2026 when that legislation became effective. Given that FY 2025-2026 had only four months of data at the time of the audit, it is recommended that these population tests be performed through expanded audit procedures listed below within the recommended follow-up phase within the "Audit Approach" section. Transaction testing was performed, where possible, and if these tests could not be performed due to the limitations noted then control testing was performed (where controls were in place) to gain as much audit coverage as possible.

Both types of audit tests were performed throughout the audit, and the results were used as the fact-base to generate the findings reflected in this report.

The audit team leveraged data analytic procedures to evaluate the results of the network service provider survey that was administered to evaluate provider satisfaction as well as to gain insights into non-ME personnel perspectives on operational performance. The results of the survey can be found in the "Provider Survey Results" section below. Analytic audit procedures were also leveraged to evaluate select performance measures from template 11 (ME progress report)– these results are shown in the "Managing Entities Process Measures" section below.

Table 3: Control Testing Sampling Approach

Control Frequency	Occurrences Across 2 Year Timeframe	Sample Size
Annual	2	2
Bi-Annual	4	2
Quarterly	8	4
Monthly	24	6
Small Populations	25-60	6
Large Populations	61+	10% up to 25

The audit was performed using a three-phased approach:

A. Planning and Mobilization – this phase included the following activities:

- Obtained data/ population and documentation requests.
- Reviewed ME contracts with the Department and identified key financial and operational requirements.
- Reviewed ME operational, compliance, financial, and accounting policies.
- Created a comprehensive audit project plan.

B. Fieldwork Execution – this phase included the following activities:

- Performed ME site visits according to established site visit guidelines/ protocols (See Table 4).
- Conducted stakeholder interviews, reviewed policies and documentation, and conducted process and system walkthroughs/ observations using the defined audit program and compliance checklist.
- Refined audit testing approach based on ME site visits and subsequent to the review of policies and documentation.
- Performed additional testing and validated findings with ME and Department stakeholders.

C. Reporting – this phase included the following activities:

- Prepared draft report (with approximately two-thirds of testing completed).
- Provided final audit report (with testing fully completed), with prioritized (risk-ranked) findings and recommendations, to the Department. In addition, the report was provided to ME Leadership for their review and feedback prior to finalization.
- Made report edits, as appropriate, based on the Department's feedback and feedback provided by the MEs.
- Coordinated with the Department for issuance and communication of final report.

It is recommended that a fourth follow-up phase should commence upon final review of this report by key stakeholders. The follow-up phase is a standard part of audits/ assessments of this nature and is primarily used to validate timely and accurate remediation of findings noted in the report. Additionally, given that the defined audit period was prior to the effective date of HB 633, there is a near-term need to perform a more extensive follow-up review that covers activities after the HB 633 and ME contract effective date.

Recommended audit follow-up procedures are as follows:

- **Compliance and control re-testing:** In instances where compliance and internal control activities were deemed ineffective as a part of this audit, it is recommended that re-testing procedures be performed to verify that root cause issues have been remediated, and implemented changes are functioning as intended. **[Tentative timing – February/ March 2026]**
- **Testing newly implemented controls:** Corrective actions will require the MEs to design and implement new financial and operational controls. It is customary to evaluate the design and operating effectiveness of newly implemented controls to verify that financial, operational and/or compliance risks are being adequately mitigated. Timely validation of new controls facilitates more efficient audits in the future with less time spent on re-testing. **[Tentative timing – July 2026]**
- **Expanded audit procedures:** Perform more detailed review of key risk areas once complete data sets are available (e.g., Medicaid eligibility data); where the accelerated audit timeline prevented the execution of desired testing (e.g., auditor's independent administration of service provider and service recipient surveys) and deeper evaluation of financial and operational requirements with a July 1, 2025[3], effective date. **[Tentative timing – July 2026]**
- **Continuous auditing/ monitoring:** Audit follow-up procedures may also include continuous monitoring activities which will allow the Department to have more timely insight into the operational integrity of high-risk areas. Ongoing monitoring audit procedures allows the Department to assist in the prevention and/or detection of issues and reduces the volume of testing to be performed on a biennial basis as continuous monitoring procedures would be performed at more frequent intervals. **[If implemented, the continuous monitoring program would be ongoing]**
- **Training and education (optional):** Department and ME staff should attend training sessions on risks, controls, audit evidence, etc. ME staff can use the learning to assist in the design and implementation of controls that address identified deficiencies and can leverage the practices going forward to improve the financial and operational control environment. **[Tentative timing – January/ February 2026]**

The nature, timing, and ownership of the follow-up procedures recommended above will be determined by the Department.

Audit Execution Timing and Governance

The planning phase of the audit kicked off on September 22, 2025, with fieldwork beginning the week of September 29, 2025. Throughout the fieldwork phase ME site visits were conducted as depicted in Table 4 and remote auditing was performed when the audit team was not physically at the ME location. Due to the accelerated timeframe of this audit, the fieldwork and reporting phases overlapped with the first draft of the report that was submitted to the Department on October 31, 2025, while the remaining audit tests were completed. The audit report, with all testing complete, was submitted to the Department for review on November 14, 2025. This final audit report, dated December 1, 2025, incorporates feedback (where appropriate) obtained from the Department and ME stakeholders during the report review process.

Table 4: Financial and Operational Audit Timeline

Deliverable or Key Project Milestone	Timeline
Project Plan	September 26, 2025
Weekly Status Report (Weekly)	September 29, 2025 – November 24, 2025
Site Visit: Broward Behavioral Health Coalition	October 8 – 10, 2025
Site Visit: Southeast Florida Behavioral Health Network, Northwest Florida Health Network, Lutheran Services Florida Health Systems	October 13 – 15, 2025
Testing Milestone 1 – 1/3 of testing complete across 4/7 MEs, relevant potential findings and recommendations submitted for review by EY to DCF	October 20, 2025

[3] The expanded audit procedures should occur after remediation activities, to address the findings outlined in this report, have been in place for at least 6 months. Ongoing monitoring by the Department, will continue as necessary.

Deliverable or Key Project Milestone	Timeline
Site Visit: Central Florida Behavioral Health Network, Central Florida Cares Health Systems, Thriving Mind South Florida	October 27 – 29, 2025
Draft Financial and Operational Audit Report	October 31, 2025
Testing Milestone 2 – 2/3 of testing complete, relevant potential findings and recommendations submitted for review	November 3, 2025
Testing Milestone 3 – testing complete, relevant findings and recommendations submitted for review	November 14, 2025
Updated Financial and Operational Audit Report	November 14, 2025
Report review process	November 14 – 25, 2025
Final Financial and Operational Audit Report	December 1, 2025

In order to execute the audit in an efficient and effective manner within the required timeframe, a robust governance process was put in place to facilitate timely and effective communication of status, findings, and potential delays with requested data and/ or documentation. The governance structure including meeting cadences, status reporting frequency, documentation tracking, etc. are depicted in the graphic Table 5.

Table 5: Governance Structure

<table>
<tr><th>Governance Tool</th><th>Purpose</th></tr>
<tr><td>Predictable Meeting Cadence</td><td>Held a strong, predictable meeting cadence to facilitate discussions amongst the Department, EY, and the MEs. This allowed transparency and collaboration to address any questions or comments on the audit procedures early in the process to help mitigate risk to the accelerated timeline to conduct the audit. Reference Table 4 for the audit timeline.

<table><tr><th>Meeting</th><th>Cadence</th></tr><tr><td>Steering Committee</td><td>Bi-weekly</td></tr><tr><td>Project Lead Connect</td><td>2x weekly</td></tr><tr><td>ME Weekly Status</td><td>1x weekly</td></tr><tr><td>Ad hoc Meetings</td><td>As needed</td></tr></table></td></tr>
<tr><td>Meeting Minutes</td><td>Took meeting minutes in all meetings with the Department and MEs to provide a formal record of what was discussed and the action items that were decided during moments working together throughout the audit, ensuring a clear account of the proceedings for future reference. Minutes were taken to hold participants accountable for their commitments and actions, as they included assigned tasks and deadlines. They also facilitated communication among team members and stakeholders who may not have been present, keeping everyone informed about decisions and discussions.</td></tr>
<tr><td>Weekly Status Report</td><td>EY provided a weekly update to the Department on the status of the audit deliverables and timeline of the audit including any risks or issues.</td></tr>
<tr><td>Audit Documentation Request Tracker</td><td>Proper tracking of all data requests to the MEs allowed for more organized structure and follow-up protocols. This includes daily tracker submission to the Department, and individual trackers that were coordinated with each ME.</td></tr>
<tr><td>RAID (Risks, Actions, Issues, Decisions) Log</td><td>Tracked all risks, actions, issues, and decisions that impacted the progress of the audit and associated deliverables.</td></tr>
<tr><td>ShareFile</td><td>Facilitated secured filesharing between the Department, MEs, and EY for audit documentation.</td></tr>
</table>

In addition to the formally established governance protocols outlined above, the Department, EY, and the ME auditees remained flexible throughout the process to accommodate adjustments necessary to meet the audit objectives within the required timeline.

Audit Finding Ratings and Definitions
When assessing the significance of findings noted, consideration must be given to the possible impact (residual risk) that could result due to the process and/ or control deficiency. The rating of findings may also be influenced by other criteria such as the adequacy of supervision and the level of awareness of internal controls by leadership at each ME, as well as the effectiveness of monitoring other existing and/ or emerging risks. Given the unique conditions and requirements that may be encountered, the Auditor may use professional judgement to consider some criteria to be more important than others when assigning ratings to each finding.

Table 6: Rating Criteria

Ratings:	
High Risk	Issues that require Department and ME leadership's immediate attention. High Risk issues may prevent the achievement of financial and operational requirements/ objectives. Action plan(s) for resolution is required immediately, and follow-up procedures should be performed to verify resolution.
Medium Risk	Issues that call for ME leadership attention but do not necessarily warrant escalation to the Department. Medium Risk issues may impede (but not necessarily prevent) the achievement of financial and operational requirements and objectives. Action plans for resolution are required, and follow-up procedures should be performed to validate issue closure.
Low Risk	Process improvements that do not necessarily impede or prevent the achievement of financial and operational requirements and objectives, due to the presence of compensating controls or other risk mitigation methods, and do not necessarily call for the Department's attention. Resolution is based on ME leadership discretion.

If/ when recommendations for improvement are accepted by the Department and ME leadership, the remediation plans and timeline for resolution will be determined at the individual finding level.

While this section of the report is focused on prioritization of findings and rating criteria, it is important to make the distinction between findings, observations and other terminology used to categorize the audit results. The key terms relevant for this report are defined below.

- **Observations** – throughout the execution of the audit there will be noteworthy information that is not only documented in the audit work papers but is also shared with key stakeholders through the audit report. Anything deemed reportable by the auditor are referred to as "observations". When determining whether an item is a reportable matter (i.e., an observation), consideration is given to the materiality/ significance of the matter, the level of potential risk exposure it presents for the organization, stakeholder expectations, and auditor professional judgement and ethical standards (e.g., Institute of Internal Auditors (IIA) Code of Ethics (objectivity and integrity) and Institute of Internal Auditors Standard 2410.A1 (communication of audit results)). There are four main categories of observations that will be referenced in this report:
    - **Findings** – as noted in the previous section, findings arise from process or control deficiencies. For this audit, instances of non-compliance or partial compliance with legislative or contractual requirements are also categorized as findings.
    - **Commendable practices** – some observations are positive in nature and are deemed reportable to provide broader context for the overall control environment. For this ME financial and operational audit, commendable practices may form the basis of leading practices that could be adopted by other MEs to drive financial and operational efficiencies.
    - **Out of period observations** – some observations resulted from the testing of legislative or contractual requirements that were in place subsequent to the defined audit period. For example, requirements associated with HB 633 and the updated ME contracts with the Department that were effective July 1, 2025, but not formally audited in the period under review

established in HB 633 (FY 2023-2024 and FY 2024-2025).
- **Other opportunities for improvement** – these are observations that do not rise to the level of a finding but if implemented, may have the potential to provide incremental gains to financial and operational process efficiency.

Commendable Practices Across MEs

The audit was conducted in an accelerated timeline requiring significant time and input from both the auditors and auditees. Throughout the duration of the audit, the MEs displayed several commendable practices/ behaviors to facilitate the successful and timely completion of the audit – below are a few highlights of commendable practices:

- **Responsiveness** – MEs provided requested documentation as quickly as possible and sought to collaborate with audit team in instances where requests were not fully clear or understood. The timely responses and collaborative approach with the audit team facilitated efficient execution across all three phases of the audit.
- **Highly engaged leadership team** – key ME leaders attended and were engaged during the audit kick-off meeting and the multi-day onsite sessions. This required adjustment to schedules and flexibility on the part of the ME leaders and their organization. The engagement of the ME organizations accelerated the pace of audit fieldwork including documentation and validation of findings.
- **Willingness to understand the audit process and implement procedures to enhance the control environment** – given that this was the first operational and financial audit of its kind for the MEs, there were no prior protocols to follow. ME leaders and their organizations used the audit as an opportunity to understand the audit process in order to be prepared for future reviews. Moreover, certain MEs explicitly expressed interest in understanding the mechanics of internal controls to leverage the knowledge to further strengthen their business practices and overall control environment.
- **Transparency** – as noted above, a culture of responsiveness was prevalent across the MEs. Additionally, MEs displayed transparency by providing requested documents/ data and being forthcoming with known issues when audit inquiries were made.

Audit Results Summary

In order to determine the financial and operational domains that warrant more detailed evaluation, a risk assessment was conducted and the financial and operational areas shown below were determined to have the highest direct impact on the MEs' ability to adhere to HB 633[4] and the Department's contractual performance requirements. The audit objectives and associated test plans were designed to evaluate these areas, with each ME audited against the same/ similar criteria (to the extent possible) to generate audit results that are comparable across the seven MEs. The audit program was created to evaluate over 100 policies, processes, standards and requirements across financial and operational areas at each ME. For reporting purposes, the audit results have been summarized across thirteen key financial and operational focus areas as shown in the table below. ME performance within each of the key financial and operational domains is shown in Table 7 below.

Table 7: Audit Results across MEs

Financial Domain							
Key Focus Areas	**BBHC**	**SEFBHN**	**NWFHN**	**LSF**	**CFBHN**	**CFCHS**	**TMSF**
Funding allocation - Evaluation of policies and procedures associated with allowable costs and funding allocation to assess completeness, accuracy and alignment with contractual requirements.							
Expenditure allowability and tracking - Review of internal controls and sample testing of invoices and expenditure transactions to assess the alignment and supportability of delivered behavioral health services with expenditures.							

[4] As the effective date of HB 633 was subsequent to the defined audit period, testing results associated with HB 633 requirements were listed as "out of period observations" and not findings.

Financial Domain							
Key Focus Areas	**BBHC**	**SEFBHN**	**NWFHN**	**LSF**	**CFBHN**	**CFCHS**	**TMSF**
ME vs. Medicaid funding - Evaluation of documented processes and controls associated with the payment of services to be funded by Medicaid vs. by the ME. This included evaluation of the processes to identify funding sources at the time of service delivery and retrospective analyses performed to monitor the appropriateness of payments made.	Not Rated - see finding (B) in the key themes section below. Note: The finding related to the unavailability of Medicaid data to evaluate the appropriateness of payments made is listed in this report as "Not Rated". While the Risk exists that payments could be made inappropriately, the severity of this finding could not be assessed as the data to quantify this finding was not available. As of the time of finalization of this report, the Department had analyses underway leveraging Medicaid data obtained from the Agency for Health Care Administration (AHCA) to quantify the impact of this finding.						
Financial contract requirements compliance - Assessed the timely submission of the SAMH Managing Entity Monthly Expenditure Report (Template 12), the SAMH Managing Entity Monthly Carry Forward Expenditure Report (Template 13), and the Cost Allocation Plan (Template 14) to meet the deadlines set forth by the DCF/ME contract (Exhibit C3 Table 2).							
Maintenance of financial records - Assessed the retention of documentation to support complete and accurate update of financial records.							
Financial internal control environment - Assess the design and operating effectiveness of controls to mitigate (prevent or detect and correct) financial risks.							
Overall ME Result:							
Risk Ranking: High / Medium / Low							

Operational Domain							
Key Focus Areas	**BBHC**	**SEFBHN**	**NWFHN**	**LSF**	**CFBHN**	**CFCHS**	**TMSF**
Governance and oversight - review of governance frameworks and processes to determine whether there are sufficient policies and controls related to provide oversight and monitoring of operational processes (e.gs., administrative practices, related party business relationships)							
Standard operating procedures - Assess the development and retention of standard operating procedures associated with grievances processes, resource allocation, and performance measurement, as well as the validation of whether processes being performed aligned with the standard operating procedures.							
Service delivery (e.gs., access, grievances, referrals) - Assess the efficiency of tracking mechanisms over high priority operational areas and gain direct provider input to evaluate service outcome and key performance measures							
Vendor/ sub-contractor management - Evaluation of whether there are sufficient processes and controls associated with the monitoring of activities performed by third-party vendors.							
Adherence to contract performance outcomes - Evaluation of processes and controls associated with the monitoring of performance metrics and outcomes submitted by network service providers within the SAMH Managing Entity Monthly Progress Report (Template 11) (Exhibit C3 Table 2 of the DCF/ME contract).							
Data platform adoption and utilization - Assess the extent to which key platforms are being utilized, which includes an evaluation of whether proper requirements were in place to mandate and evaluate the use of the Performance Based Prevention System (e.g., PBPS) for network service providers							

Operational Domain							
Key Focus Areas	**BBHC**	**SEFBHN**	**NWFHN**	**LSF**	**CFBHN**	**CFCHS**	**TMSF**
Operational internal control environment - Assess the design and operating effectiveness of controls to mitigate (prevent or detect and correct) operational risks.							
Overall ME Result:							
Risk Ranking: High / Medium / Low							

Key Finding Themes

While each ME was provided with individual findings and recommendations for their entity, four findings/ themes were noted throughout the audit process as being applicable across multiple MEs. These key findings/ themes are outlined below.

A. Oversight controls for key financial and operational processes require enhancement

Finding Overview: Monitoring and oversight controls required to drive and sustain financial and operational discipline need to be strengthened and/ or implemented. For example, more robust controls are required to address the following:

- Payments to network service providers are made without the review of supporting documents, thereby increasing the risk of inaccurate and/or fraudulent payments. The absence of payment oversight controls allowed fraudulent payments to remain undetected for an unknown length of time at one ME. [the issue of fraudulent payments was noted for Central Florida Cares Health Systems (CFCHS), which resulted in the recovery of $31,466].
- The treatment payment process does not have robust controls in place to prevent Medicaid-covered services from being paid by the ME. There is no mechanism to gain assurance that payments are made for eligible individuals and for non-duplicative services.
- Key third-party vendors are not adequately monitored from a contractual or service delivery standpoint. For example, contracts have been finalized with pre-payment terms that may adversely impact the MEs' cashflow and Service Organization Control reports for key vendors are not being reviewed to verify that the required controls are in place to effectively support the vendor's service delivery.

Overall, there is need for a risk management/ internal audit program with documented protocols for risk monitoring and mitigation.

Potential Impact: Without sufficient governance and oversight controls, ME leadership's ability to make informed decisions may be limited, increasing the potential for operational challenges, compliance issues, and financial inefficiencies that could affect service quality and organizational performance.

Recommendations: Outside of the biennial audits required by HB 633, from an overall governance/ oversight perspective, a risk management/ internal audit program should be implemented to provide more ongoing and timely monitoring of the control environment. It is essential that functional reporting rolls up to the Department and ME Board (as appropriate) to maintain independence of the internal audit function.

This risk management/ internal audit function would provide the ongoing risk monitoring required to maintain a robust control environment.

For the specific finding/ theme highlighted above, ME leadership should consider the following:

- Implement a quality assurance process for network service provider payments that includes verifying a sample of payments against supporting documents prior to payment. Given the volume of payments, a sample-based approach using a variety of sampling techniques is recommended (e.g., random sample, payments over a specific dollar threshold, payments related to specific services etc.) to perform the quality assurance review.
- Determine the system enhancements and data elements needed to identify Medicaid eligible service recipients to reduce instances of duplicate or unallowable payments. Through discussions with the Department, it was noted that a Claim System Modernization initiative is underway and will extend over the next 18 months. The Department indicated that the claim modernization initiative is intended to address the known deficiencies in the current systems. However, the specific issues to be addressed through the initiative were not validated by the audit team, as the scope of the new system is still under

development.

- Implement a formal vendor risk management program to be applied to key vendors. The program should outline requirements for contracting, service level metrics, invoice review, and approval.

B. Limited access to complete and accurate service recipient claim and encounter information

Finding Overview: Throughout the audit it was noted that key data required to make service recipient coverage determinations and to perform detailed financial and operational analyses was not consistently available at the individual encounter level.

Specifically, for Medicaid audit testing, the following issues prevented the execution of population testing:

- Financial and Services Accountability Management System (FASAMS) individual encounter level data does not contain the elements required to confirm Medicaid eligibility. There is a "Medicaid Eligibility" field within the system, however, per discussion with the Department, the data contained in this field is not reliable. This is a known issue that has been acknowledged by the Department. Medicaid eligibility can be validated through alternate methods, but the data elements required to accurately confirm eligibility were not available (such as effective date, term date, etc.) and should be tested within the recommended fourth follow-up phase.
- In addition to the eligibility issue, the various data sets extracted from Financial and Services Accountability Management System (FASAMS) did not contain the Medicaid identification number, which is the unique identifier needed to facilitate the analyses and testing to validate the appropriateness of ME payments made for individuals who are also Medicaid enrollees.

The data challenges are not limited to the Medicaid findings noted above but extend across the service population, for example:

- The service-level data set provided did not include standardized outcome data or billed/allowed amounts for the service which are required fields to conduct a comprehensive outcome vs. expenditure analysis/ reconciliation.

These issues also prevented the performance of the detailed client outcomes analysis where services administered would be compared to outcomes and ME payments to determine accuracy/ reasonableness.

These issues impacted audit testing execution and limited the ability of ME leadership to perform these types of analyses for monitoring purposes.

Potential Impact: Inability to accurately determine whether services should be ME-funded or Medicaid funded could have a significant financial impact on the Department as funds may be inappropriately disbursed by the ME to fund services that should be paid for by Medicaid.

More broadly, the unavailability of key data limits each ME's ability to fully evaluate the effectiveness and outcomes of the various substance abuse and mental health programs. This can adversely affect each ME's strategic decision-making abilities, thereby impacting access to and quality of services provided.

Recommendations: Through discussions with the Department, it was noted that a Claims System Modernization initiative is underway and will extend over the next 18 months. The Department indicated that the claim modernization initiative is intended to address the known deficiencies in the current systems. However, the specific issues to be addressed through the initiative were not validated by the audit team, as the scope of the new system is still under development.

While the claim modernization initiative is underway, each ME should implement compensating/interim controls to mitigate as many risks as possible. For example, an analysis could be conducted of payments made by both Medicaid and the MEs as in these instances the primary payer could be more easily determined.

C. System access and segregation of duties controls should be strengthened

Finding Overview: Processes to perform system access entitlement (role-based) reviews and password-protect files with sensitive data were not consistently in place. Limited controls in this area resulted in observed instances of:

- Untimely removal of system access for terminated employees and service providers.
- Critical business processes were being executed using Microsoft Excel files without password protection and version control mechanisms. Additionally, certain files contained complex formulas

which were not understood by ME process owners, which increases the risk that issues with calculations may not be detected and escalated for resolution since the users do not have a clear understanding of how these formulas are intended to operate.

- Systems are not configured to prevent unauthorized adjustments by individuals who have a privileged user role. This issue presents a segregation of duties concern, as unauthorized changes to system functionality and/ or data could be made without being detected. There were no instances of unauthorized system changes detected during the audit, however, during audit testing it was observed that an employee with privileged/ super-user access had the ability to adjust their payroll outside of the established compensation grid for their role without additional review/ approval. Internal Control standards indicate that no single person should be able to change payroll data, even if they have super-user access. This vulnerability raises concerns about the potential for improper changes to compensation data, which could lead to financial discrepancies, fraud and/or compliance issues. (Please note: the employee was asked to make this change by the audit team for testing purposes to verify whether the change could be made without approvals. The employee restored the system to its original state once the audit testing was completed).
- Microsoft Excel reports are being exported from the Behavix system (which is utilized for the upload of service data (i.e., invoices) by network service providers) for manual upload into Financial and Services Accountability Management System (FASAMS) without edit restrictions for data fields, leaving risks for intentional or unintentional manipulation of data.

Potential Impact: Failure to remove system access in a timely manner for terminated employees and service providers may lead to unauthorized use of sensitive information, increasing the risk of security breaches, fraudulent activities and may result in compliance violations. Additionally, system access that results in segregation of duties concerns may lead to misappropriation of assets.

Lastly, without password protection and edit restriction controls for files and reports with confidential data, there is increased risk of inappropriate data manipulation. This could ultimately lead to inaccurate financial records, compliance issues, and potential misrepresentation of the entity's performance.

Recommendation: ME leadership should consider the following recommendations to address the identified findings:

- Include a step in the employee and service provider termination/ offboarding process to revoke system access, ensuring that access is removed on or before the termination date. Additionally, regular (at least quarterly) entitlement reviews (audits) should be conducted for key systems and applications to verify that access rights are appropriately based on employee role and status (active/ terminated). Identified discrepancies should be promptly resolved.
- Implement password protection and/ or edit restrictions on files that contain confidential information to prevent unauthorized or unintentional manipulation of data. Additionally, ME leadership should consider establishing a standardized review process for data integrity checks to improve accuracy and reliability of the data prior to use in the generation of reports, some of which may be used to manage service delivery.
- Implement segregation of duties controls for key systems, such as payroll systems, to prevent unauthorized changes. Internal Control leading practice for payroll requires separating data entry, approval, review/ reconciliation and system administration (super user activity). At the very least, an approval requirement from a separate (appropriate) approver should be triggered if payroll data is changed (even by a super-user), so that the change cannot be made effective by a single person.

D. Supporting documentation is not consistently retained by MEs in accordance with contractual requirements and to serve as audit evidence

Finding Overview: Across multiple MEs, supporting documentation was not being retained in accordance with ME contract requirements (Section 5.1. Records, Retention, Audits, Inspections and Investigations) and for the purposes of preserving an effective audit trail. There were observed instances of:

- Source documentation to support reported metrics selected for audit testing or to substantiate financial transactions (e.g., vendor invoices) were not archived in accordance with the ME's Record Retention and Disposal policy and therefore not readily available for inspection during the audit.
- Evidence was not maintained for General Ledger reconciliations to demonstrate review and approval,

resulting in the inability to validate that the process was performed in a timely and accurate manner.

- The current system for managing deadlines associated with the preparation and submission of monthly, quarterly, and annual required reports to the Department relies heavily on decentralized oversight using individual calendar reminders. This increases the risk that milestones and deadlines are not accurately coordinated amongst individuals responsible for various portions of the process thereby increasing the risk of missed deadlines, particularly when responsible parties are unavailable due to absence. There were instances of late submissions noted during the audit period at two ME which highlights the need for this process to be enhanced to meet FY 2025-2026 contract requirements.

Potential Impact: Failure to retain source documentation to support reporting and financial and operational activities/ transactions can lead to difficulties in assessing data accuracy and evaluating performance. The inability to rely on reporting for performance monitoring purposes impedes the decision-making abilities of the MEs, which could adversely impact operational, financial, and service delivery activities.

Additionally, the inability to provide source documents may hinder timely inspections and audits.

Recommendations: ME leadership should consider implementing the following recommendations to address the identified findings:

- Establish a process for archiving documentation that retains the necessary audit evidence and aligns with the Record Retention and Disposal policy in the MEs' contracts. This process should include regular audits to assess compliance, as well as training staff in proper documentation practices to ensure that all relevant materials are readily available for timely inspection.
- Develop, document, and implement a centralized process for tracking and monitoring key reporting milestones and deadlines, including timing for receipt of data, performance of analysis, and data/ report submission to the Department. The updated process should clearly indicate the roles and responsibilities of all staff members that are included in the preparation and review of the various reports.

Assumptions and limitations

One key objective of this inaugural ME financial and operational audit was to establish the baseline audit program and criteria to serve as a repeatable framework for the execution of ME audits at any cadence deemed necessary by the Department, and to be used for the biennial financial and operational audits required by HB 633. This objective was achieved.

Per the legislation, the audit review period for this first ME financial and operational audit covers FY 2023-2024 and FY 2024-2025, however, HB 633 and the current ME contracts were not effective until July 1, 2025 (FY 2025-2026). The difference between the audit period and the HB 633 / ME contract effective date, required adjustments to audit test procedures given that key HB 633 requirements identified as high priority for audit testing were not effective until FY 2025-2026. Additional steps had to be taken to validate audit test results against the ME contracts that were in force during the audit period prior to recording findings. Additionally, there were new HB 633 requirements, identified as high priority by the audit team (e.g., tracking mechanisms for both referrals and grievances, and ME system data availability for calculation of key metrics and performance measures), for which limited audit procedures were performed to gain insight into these areas even though the activities occurred outside of the defined audit period (i.e., after July 1, 2025). Any observations identified based on review of documentation outside of the audit period were categorized as "Out of period observations" and not findings. This issue will not recur for future audits.

Full population testing was limited due to the unavailability of key data required to perform these tests (e.g., Medicaid eligibility testing). Alternate audit procedures, such as internal control testing, were employed (where possible) to evaluate the design and operating effectiveness of controls within areas that population testing could not be performed due to the data availability issue. The internal control testing was performed leveraging sample-based techniques derived from the United States Government Accountability Office Financial Audit Manual standards and EY's Global Audit Methodology. However, as described in the "Audit approach" section above, the results of the control tests cannot be used to draw conclusions about the entire population from which the test sample was selected. However, these control tests were able to serve as alternate audit procedures to provide insight into the in-scope areas since full population testing could not be performed.

This audit was conducted in an accelerated time frame. To meet the audit objectives within this limited timeline, a risk-based approach was used to prioritize the financial and operational areas that would be subject to detailed audit review. During the 6 weeks of active fieldwork, focus was placed on the financial and operational processes deemed high risk. The findings presented in this report are fact-based and supported by audit work papers and evidence. It is recommended that an audit of FY 2025-2026 be conducted as early as July 2026 to provide results for a full year with HB 633 and ME contract requirements in force.

Additional Observations

Throughout the course of the audit, additional observations arose that were either outside of the defined audit period (and therefore could not be classified as a finding) or are observations that do not rise to the level of a finding but if implemented, may provide incremental process efficiency. Additional observations outside of the defined audit period are referred to as "Out of Period Observations" and additional observations that may contribute to process efficiency are referred to as "Other Opportunities for Improvement". For a summary of the definitions of the various categories of observations please see the "Audit Finding Ratings and Definition" section above.

Out of Period Observations

As noted above, out of period observations do not fall within the FY 2023-2024 and FY 2024-2025 audit period, however, given that a key objective of this audit is to evaluate ME response to HB 633 requirements, it was essential to perform additional audit work during FY 2025-2026 when the HB 633 requirements became effective. Although these observations fall outside of the legislatively defined audit period, the audit work was conducted to assess the current status of ME compliance with key HB 633 requirements to support proactive improvement efforts and strengthen the overall compliance framework for MEs moving forward. The out-of-period observations noted below do not always apply to every ME, however, these observations were prevalent across the group and represent common themes identified during the audit. Individual ME observations can be found in their corresponding report.

A. Policies and Procedures Should be Aligned with Current Department and Contractual Requirements

Overview: Key policies and procedures are outdated or inconsistent with current contractual requirements. For example, for certain MEs it was noted that:

- The definition of grievance in one policy does not align with the definition established by the Department in the updated ME/ DCF contract that is effective as of July 1, 2025 (section C.1.3.8 – Grievance Procedures).
- Conflict of Interest policies and procedures do not incorporate the new $65,000 threshold requirement introduced in the updated ME/ DCF contract that is effective as of July 1, 2025 (section C.2.2.9 – Related Parties).

Policies and procedures should accurately reflect the processes currently in place including contractual requirements with the Department. (See Exhibit C, Section C-1.3.1.4.15 Grievance Procedures of ME/ DCF Contract and See Exhibit C, Section C.1.3.8.1, for contract requirements associated to the examples noted above). Additional observed instances of policy misalignment are referenced within the corresponding individual ME level reports.

Impact: Misaligned or outdated policies create ambiguity, increasing the likelihood of inconsistent application of requirements, improper classification of grievances and complaints, and potential noncompliance with contractual standards. Failure to incorporate new Conflict of Interest thresholds and updated definitions may hinder effective oversight, compromise transparency, and elevate risk. These gaps reduce the ME's ability to ensure uniform implementation and consistent execution of operational and financial processes thereby weakening the reliability of the compliance framework and overall control environment.

Recommendations: To strengthen alignment and ensure compliance, the MEs should:

- Update Core Policy Definitions: Revise policies to clearly distinguish between grievances and complaints and incorporate all relevant Department language, including acknowledgment, documentation, and resolution expectations.
- Validate Consistency Across Policies and Incorporate New Requirements: Review and update related

policies and procedures to validate that definitions, timelines, workflows, and documentation standards are fully aligned with current contractual and regulatory requirements, such as the new $65,000 threshold and associated disclosure, monitoring, and mitigation obligations.

- Establish a Formal Policy Governance Process: Develop a structured governance mechanism to track new or changing requirements, identify responsible owners, assign deadlines, and ensure timely updates to policies and procedures.
- Train Staff and Providers on Updated Policies: Provide updated training to ensure consistent understanding and implementation of revised requirements across all ME functions. Where applicable, validate that updated requirements are clearly passed through to subcontractors, including monitoring and accountability provisions necessary to support ongoing compliance.

B. 24/7 Referral Tracking Should be Improved

Overview: Per the updated contractual requirements (Exhibit E, Section E.1.3.3 per C.1.2.10) related to HB 633 requirement as stated in 394.9082(3)(n)1.a.(III), MEs are required to respond to 95% of after-hours referral requests by the following business day and maintain a monitoring log that can be submitted to the Department upon request. Our review revealed that the majority of MEs did not maintain an appropriate monitoring log with fields that would facilitate the ability to measure against that requirement. Additionally, a complete and accurate population of referrals across several MEs could not be provided because referral management primarily occurs at the individual service provider level, rather than through a centralized process. It was noted that one ME was tracking after-hours referral response timeliness centrally (ME level), however, the ME was noncompliant with the new 95% after-hours referral response requirement of one business day. . In instances where MEs had some version of a tracking log, inconsistencies were noted such as how the after-hours calls response date and time were being recorded to serve as evidence of a timely response. Additionally, in most instances the versions of the purported logs did not have evidence of secondary reviews/ sign offs, or evidence of the referral resolution.

Impact: The absence of a central tracking log, documented secondary reviews, formal signoffs, and clear closure indicators (date and time) limits the ME's ability to demonstrate timely and accurate referral follow-up and resolution. Additionally, in instances where after-hours referrals are tracked at the individual provider level rather than through a centralized ME process, the MEs may not be able to adequately monitor the completeness and accuracy of after-hours referral requests. This prevents reliable measurement of performance against the updated contractual requirement to respond to 95% of after-hours referrals by the next business day, may hinder the ME's ability to appropriately manage service recipient referrals and provide monitoring logs upon the Department's request, and limits the ME's capacity to identify performance trends necessary for timely remediation.

Recommendations:

- Integrate Contractual Metrics into Ongoing Monitoring: Incorporate the 95% response-time requirement into ME monitoring dashboards, routine reporting, and Continuous Quality Improvement activities to ensure ongoing visibility into performance and timely remediation of deficiencies.
- Centralize Referral Tracking: Develop and implement a centralized ME-level referral management log that consolidates all after-hours referral requests from service providers. The log should capture key data elements (e.g., referral date/time, response time, resolution status) to allow accurate calculation of compliance with the 95% next-business-day response requirement.
- Add a Formal Resolution Column: Modify the log to include a dedicated column indicating resolution status and date. This will support timely identification and tracking of open items and enable clear reporting.
- Implement Secondary Review and Sign-Off Controls: Establish a process requiring supervisory review and documented sign-off for each entry in the log to confirm that follow-up actions were completed and appropriately resolved.
- Strengthen Policies, Training, and Data Validation: Create or update policies and procedures that define roles, responsibilities, and processes for after-hours referral tracking. Provide training to relevant staff and conduct periodic audits or reconciliations to validate completeness and accuracy of data.

C. Grievance Resolution and Oversight Tracking Processes Need to be Examined

Overview: Grievance and complaint logs are oftentimes incomplete and lack a final resolution status column, reference to closure dates for resolved incidents, and documentation of periodic review signoffs. Incomplete or inconsistent grievance logs make it difficult to verify timely resolution, identify systemic issues, or demonstrate compliance with the Department and contractual oversight responsibilities. Additionally, several MEs report not having any grievances during the audit period, suggesting a risk of potential improper complaint classification. See Exhibit C, Section C-1.3.1.4.15 Grievance Procedures of the ME / Department Contract.

Impact: The absence of required fields—such as final status, closure date, and evidence of supervisory review—limits the ME's ability to demonstrate timely and complete grievance resolution. Incomplete or inconsistent logs may hinder trend identification, impede the ME's ability to detect systemic issues, and reduce transparency into logged concerns. These gaps increase the risk of noncompliance with the Department contractual requirements and weaken the MEs' overall quality oversight framework. Additionally, without standardized documentation and periodic review, the MEs cannot reliably validate that all grievances were addressed and resolved in accordance with policy.

Recommendations:

- Standard Required Data Fields: Incorporate required elements into the grievance log, including final status, closure date, follow-up actions, responsible staff, and escalation/notification information (if applicable).
- Implement Review and Sign-Off Controls: Require supervisory or compliance review at defined intervals, with documented signoffs to verify accuracy, completeness, and timely closure.
- Improve Completeness and Accuracy Controls: Conduct periodic reconciliations against other data sources (e.g., service provider logs, hotline records, complaints received via email/phone) to validate all grievances are captured.
- Leverage Automation Where Feasible: Use automated tools to enforce required fields, timestamp closure dates, and enable reporting dashboards to identify trends and monitor timeliness.
- Update Policies and Training: Update policies and standard operating procedures to reflect standardized fields, review expectations, escalation pathways, and documentation requirements, and provide training to staff responsible for intake and review.

Other Opportunities for Improvement

As described above, additional observations that may contribute to process efficiency are referred to as "Other Opportunities for Improvement". The items noted below fall within this category and the recommendations for improvement, if implemented, may improve financial and operational efficiency.

A. Data-driven Fraud, Waste, and Abuse Monitoring Should be Implemented

Overview: The majority of MEs do not employ preventive fraud, waste and abuse controls designed to proactively detect potential issues. Current processes are largely reactive, relying on complaints or monitoring findings rather than data-informed detection. Implementing analytics-driven, proactive oversight would enable MEs to identify emerging risk patterns, validate provider performance, and strengthen network oversight. Additionally, retrospective procedures driven by data analysis (rather than through complaints or other mechanisms) should be employed. See Exhibit C, Section C.1.2.7 of the DCF/ME Contract.

Impact: Without prospective as well as robust retrospective fraud, waste and abuse analytics, early indicators of improper billing, duplicate or excessive services, or providers operating outside their scope may go undetected. This increases financial and regulatory exposure for the Department and ME, limits the ME's ability to identify systemic risks, and reduces confidence in the integrity of reported services and expenditures. The absence of proactive controls also hampers ME's ability to demonstrate strong program integrity practices.

Recommendations: Develop and implement analytics to detect and prevent fraud, waste and abuse, including:

- Identifying outlier billing or service volume patterns
- Flagging duplicative or conflicting services
- Monitoring for credentialing or licensure mismatches
- Using trend analysis to pinpoint providers with high-risk utilization profiles

Incorporate these analytics into routine monitoring, update related standard operating procedures, and train staff on interpreting and acting on data insights.

B. Formal Compliance Governance Structure is Recommended

Overview: While not a contractual or regulatory requirement, formalized governance and oversight facilitates an effective compliance program. The 7 Elements of an Effective Compliance Organization as outlined by US Federal Sentencing Guidelines (FSG) serves as a widely accepted industry benchmark for establishing an effective compliance program. Across most MEs, accountability for compliance activities is oftentimes dispersed across departments and documentation of compliance review outcomes and follow-up actions varies significantly. Some areas rely on informal tracking methods rather than standardized processes. In the absence of a formal compliance committee, oversight responsibilities are fragmented, leading to inconsistent decision-making, varying escalation pathways, and delays in resolving compliance issues. At one ME, where a compliance committee existed, evidence of compliance committee meetings such as meeting minutes was not available. Additionally, operationalizing regulatory or contractual updates can be delayed without a centralized authority responsible for implementation and monitoring. See the 7 Elements of an Effective Compliance Program and Office of Inspector General Guidance, which include the following: 1) Written policies and procedures, 2) Compliance leadership and oversight, 3) Training and education, 4) Effective lines of communication with the compliance officer and disclosure program, 5) Enforcing standards: consequences and incentives, 6) Risk assessment, auditing, and monitoring, and 7) Responding to detected offenses and developing corrective action initiatives.

Impact: Fragmented accountability and inconsistent documentation reduce the ME's ability to demonstrate effective compliance oversight and monitoring. The lack of a formal governance structure increases the risk that emerging issues go unidentified or unresolved, regulatory or contractual changes are not embedded timely, and corrective actions are not monitored to completion. These gaps heighten the ME's exposure to noncompliance with DCF requirements, diminish transparency, and weaken organizational readiness to respond to audits or inquiries.

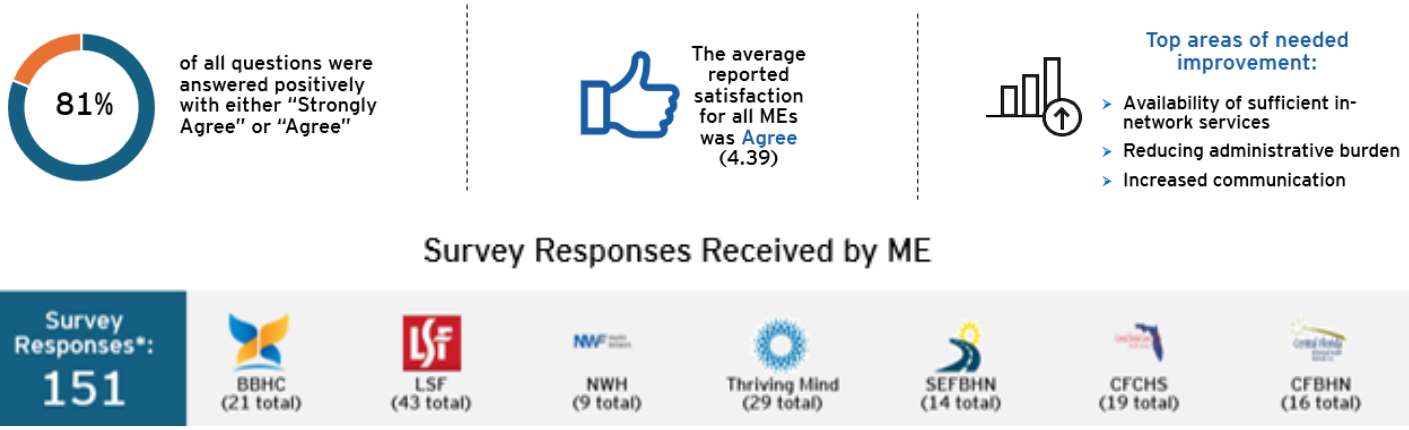
Recommendations: To strengthen governance and ensure consistent oversight, the MEs without such existing structures should:

- Establish a Formal Compliance Committee and Compliance Officer: Form a cross-functional compliance committee including representatives from Compliance, Legal, Quality Improvement, Operations, Finance, and other key areas.
- Define Clear Roles, Responsibilities, and Escalation Pathways: Document committee responsibilities, including issue review, decision-making, approval of corrective actions, monitoring of regulatory and contractual changes, and escalation procedures.
- Standard Compliance Issue Tracking and Documentation: Implement a centralized log or system to document compliance reviews, decisions, follow-up actions, responsible parties, and closure status.
- Integrate Regulatory and Contractual Change Management: Use the committee as the central authority to evaluate new requirements, assign owners, track implementation, and validate operational enablement.
- Conduct Regular Meetings and Maintain Minutes: Hold recurring meetings (e.g., monthly or quarterly) with formal agendas and documented minutes to ensure consistent oversight and accountability.

Provider Survey Results

Background
The operational scope of the audit required the use of multiple methods to evaluate ME performance. One method leveraged to evaluate key stakeholder satisfaction with ME performance and to obtain input on other key operational areas, was an anonymous survey. The survey was administered to a subset of network service providers, behavioral health practice organizations, and providers across facilities that contract with MEs for providing substance abuse and mental health services. We received responses from 151 entities out of a total of approximately 7,125 network service providers, behavioral health practice organizations, and providers across facilities. The low response rate was due to a few factors that is discussed within the conclusion section below. The survey questions were constructed to gain direct feedback on ME performance and to gain non-ME personnel perspectives on potential issues/ opportunities for improvement within high priority operational areas such as network adequacy, prior authorizations, referrals, compliance, training etc. Please note that this survey was not independently administered by EY.

The survey was issued in October 2025 and there were 151 individual survey responses. The results of the survey are summarized below.

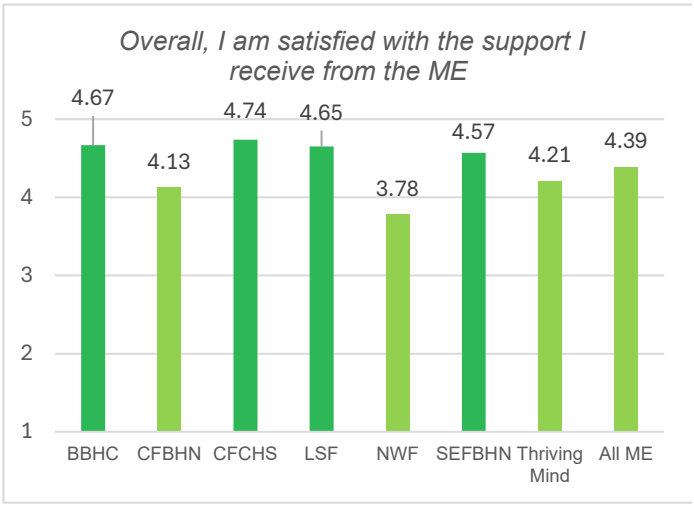


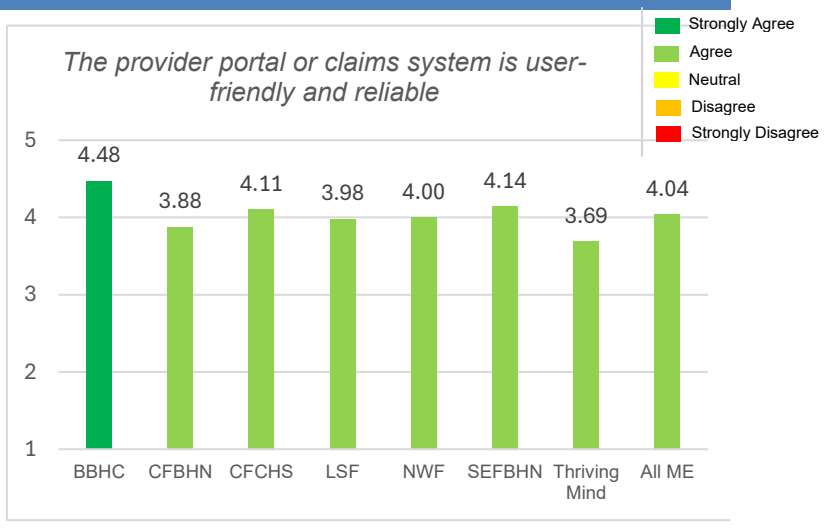
Rating Scale
The 22-question survey was answered on a scale from 1 to 5. 1 indicating "Strongly Disagree", 2 indicating "Disagree", 3 indicating "Neutral", 4 indicating "Agree" and 5 indicating "Strongly Agree."

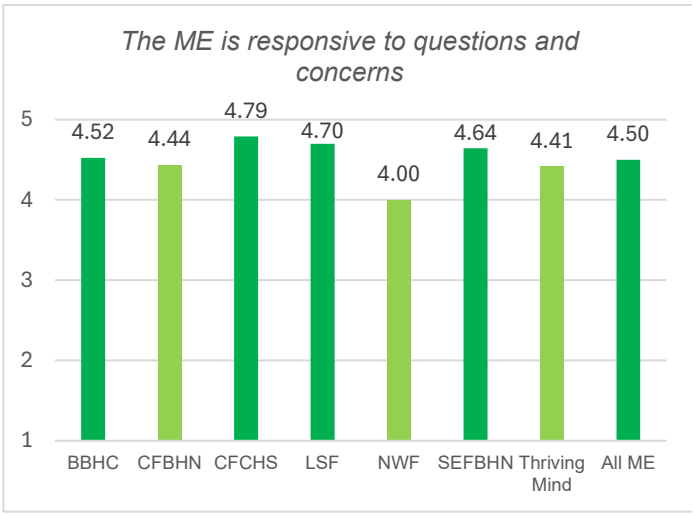
Analysis
On pages 21-23, there are graphs depicting all 22 survey questions and the respective responses received. There are eight specific survey questions that are noted on pages 21 and 22 in addition to two additional charts displaying the remaining questions showing a comparison between the MEs. The eight specific questions were chosen to reflect responses that provide a balanced representation of responses to the surveys. Individual ME survey feedback can be found in the corresponding reports.

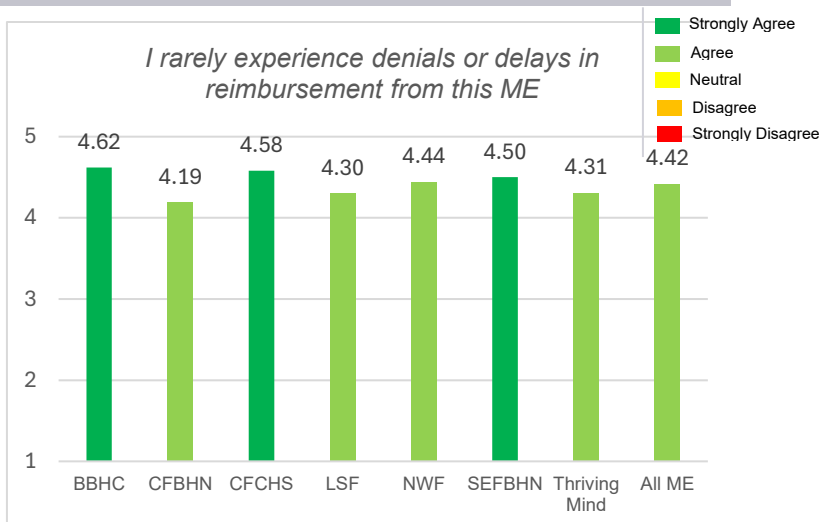
Conclusion
The results show a generally positive level of satisfaction, with comments indicating areas of improvement needed in the availability of sufficient in-network services, reduction of administrative burden, and better communication between MEs and their providers. The area of most satisfaction across MEs was "*The ME is responsive to questions and concerns,"* and the area of least satisfaction was "*There are sufficient in-network behavioral health and substance abuse services available within the provider network to meet varying levels of care."* While these results can provide insights into satisfaction from the survey recipients, network accessibility and other areas of ME operations, it important to consider the number of responses received for each ME when using these results to assess an ME's overall performance in a specific area, and when comparing performance against another ME. Ideally, the next audit should have the survey independently administered to respondents selected by the auditors with more time to conduct the survey and obtain increased responses.

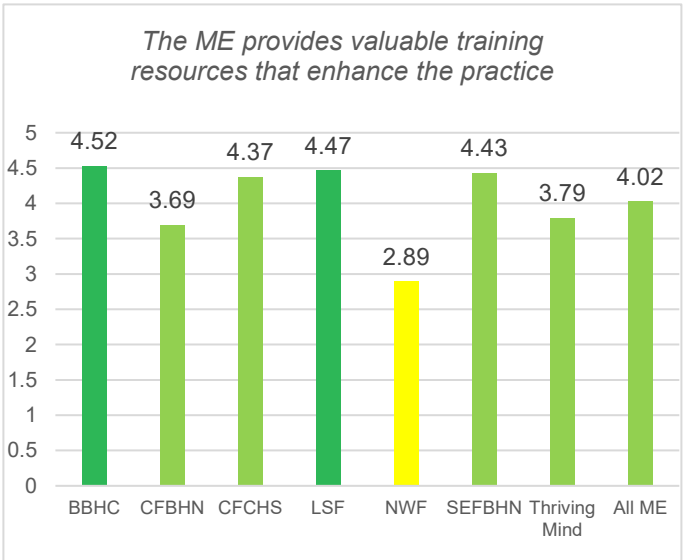
Illustrations

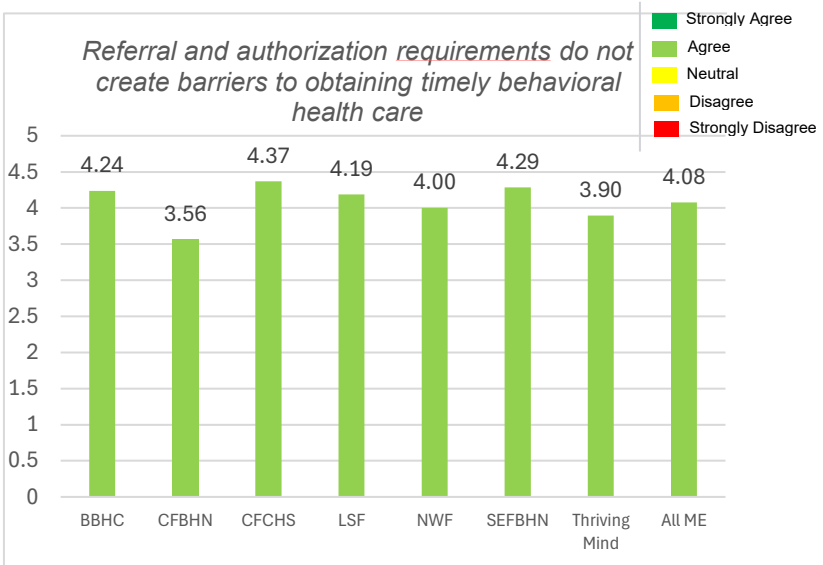




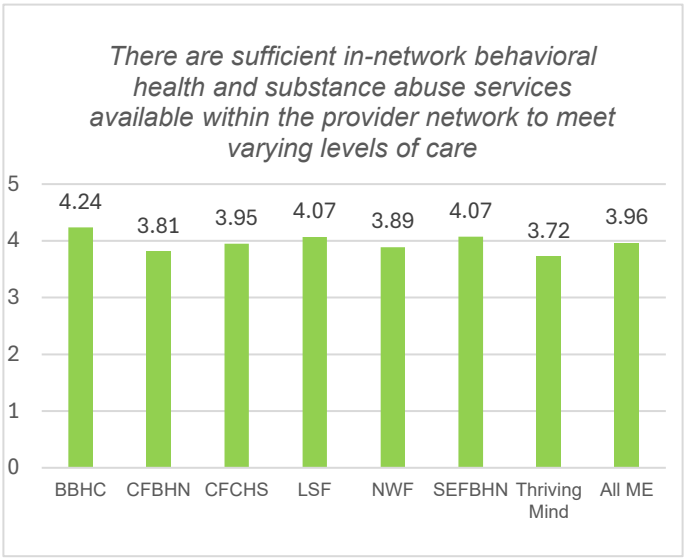


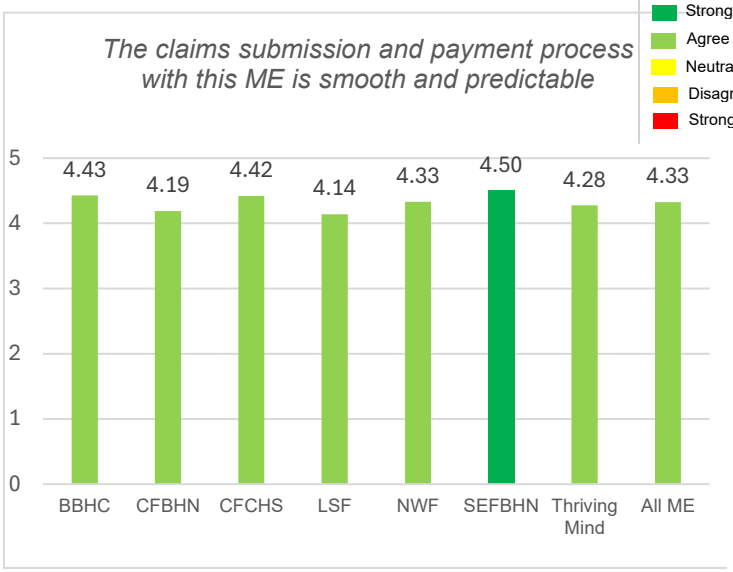




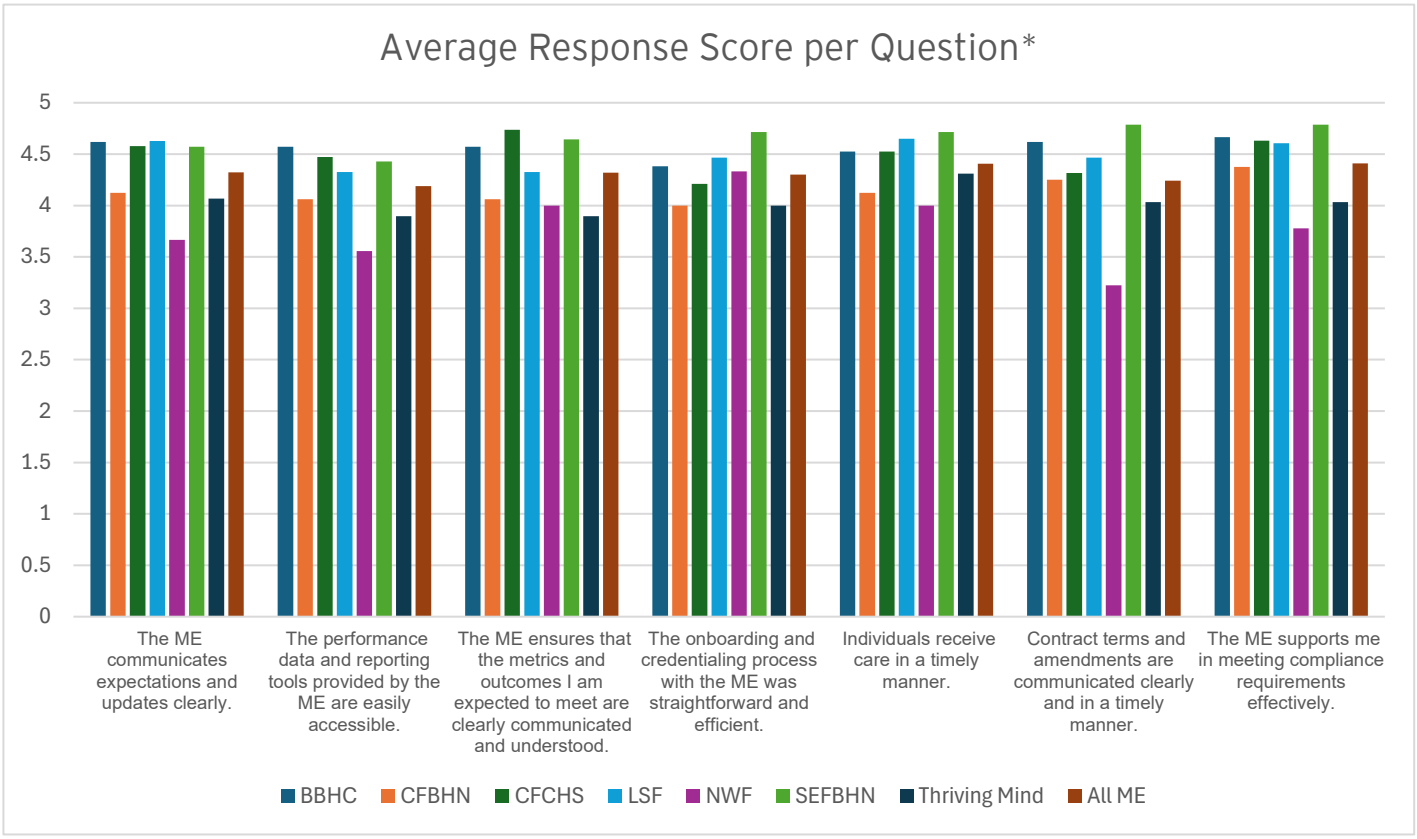


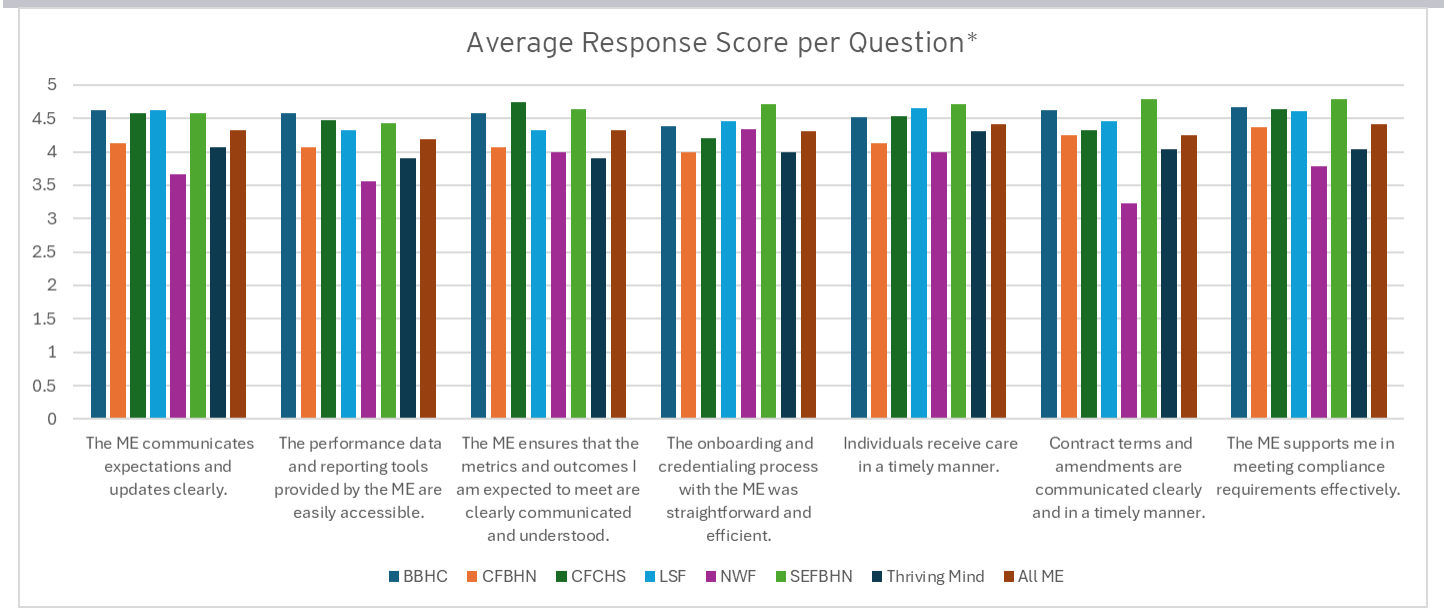
Illustrations





Illustrations





Managing Entity Process Measures Analysis

Background
Per the HB 633 requirement, as stated in 394.9082(3)(n)1.a.(V)(A), EY selected Key Performance Indicators (KPIs) to perform a comparison across the seven MEs regarding service delivery effectiveness, financial performance, and client outcomes. These performance measures were taken from ME submissions of the Substance Abuse and Mental Health (SAMH) Managing Entity Monthly Progress Report (Template 11). The selected KPIs from Table 2 of Template 11 (current Exhibit E), spanning service areas of Adult Mental Health, Children's Mental Health, Adult Substance Abuse, and Children's Substance Abuse. These measures were compared across the 7 MEs using YTD datapoints from June 2024, and June 2025.

Metrics
Subcontracted services within the ME's service location have an annual target each year per measure, with a minimally accepted level of performance for each measure equal to 95% of its annual target. The values shall be calculated as an aggregate of all applicable services reported by all subcontracted network service providers taken collectively.

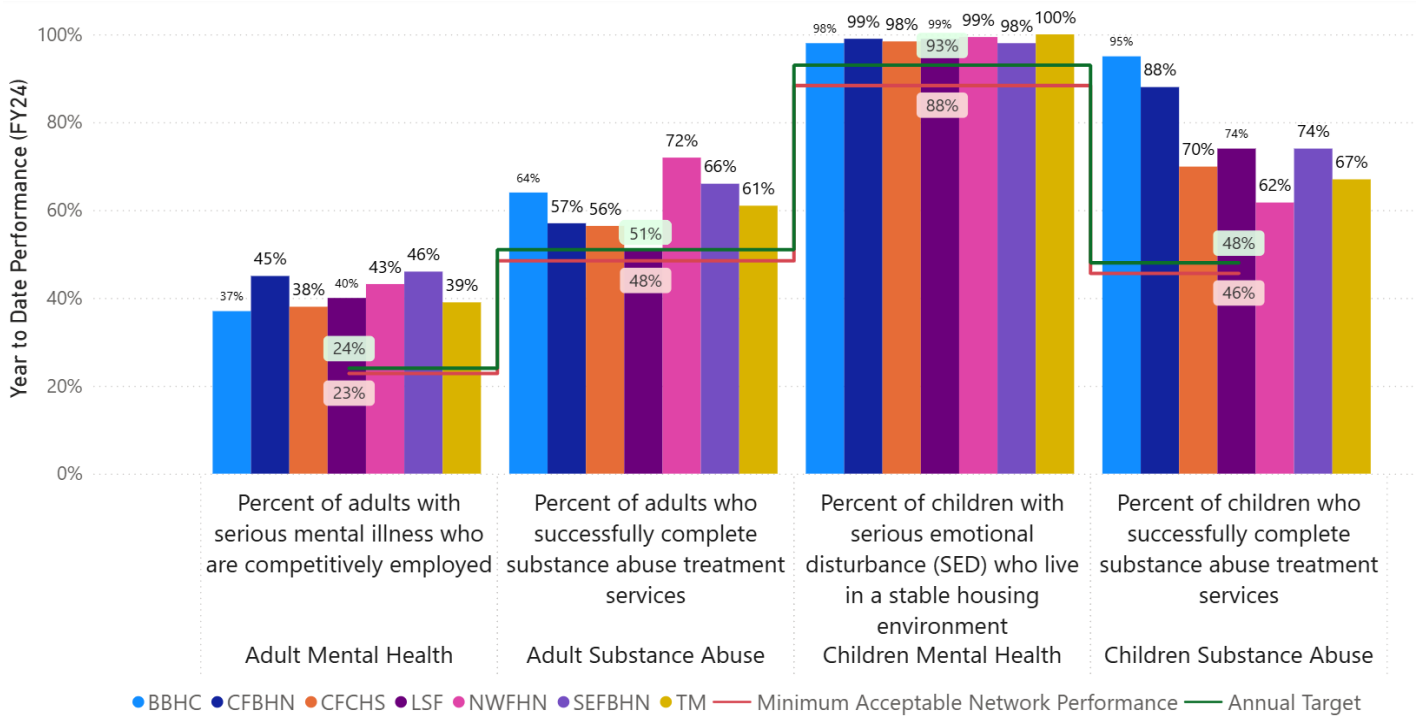
Considerations
Please note that the measures referenced cover the FY 2023-2024 and FY 2024-2025 Audit Periods, but that these measures are planned to continue in future years. Additionally, specific feedback regarding these measures was provided from the ME's regarding certain measures were below the minimally accepted level of performance can be found below.

Key Highlights
- As of FY2025, 77% of all measures reported meet the annual target, and 81% of all measures meet minimum accepted performance
- Managing Entities performed above annual targets relating to overall successful completion of the programs for the four service areas
- Stable housing is a notable challenge, due to high prices and low inventory in the Florida housing market

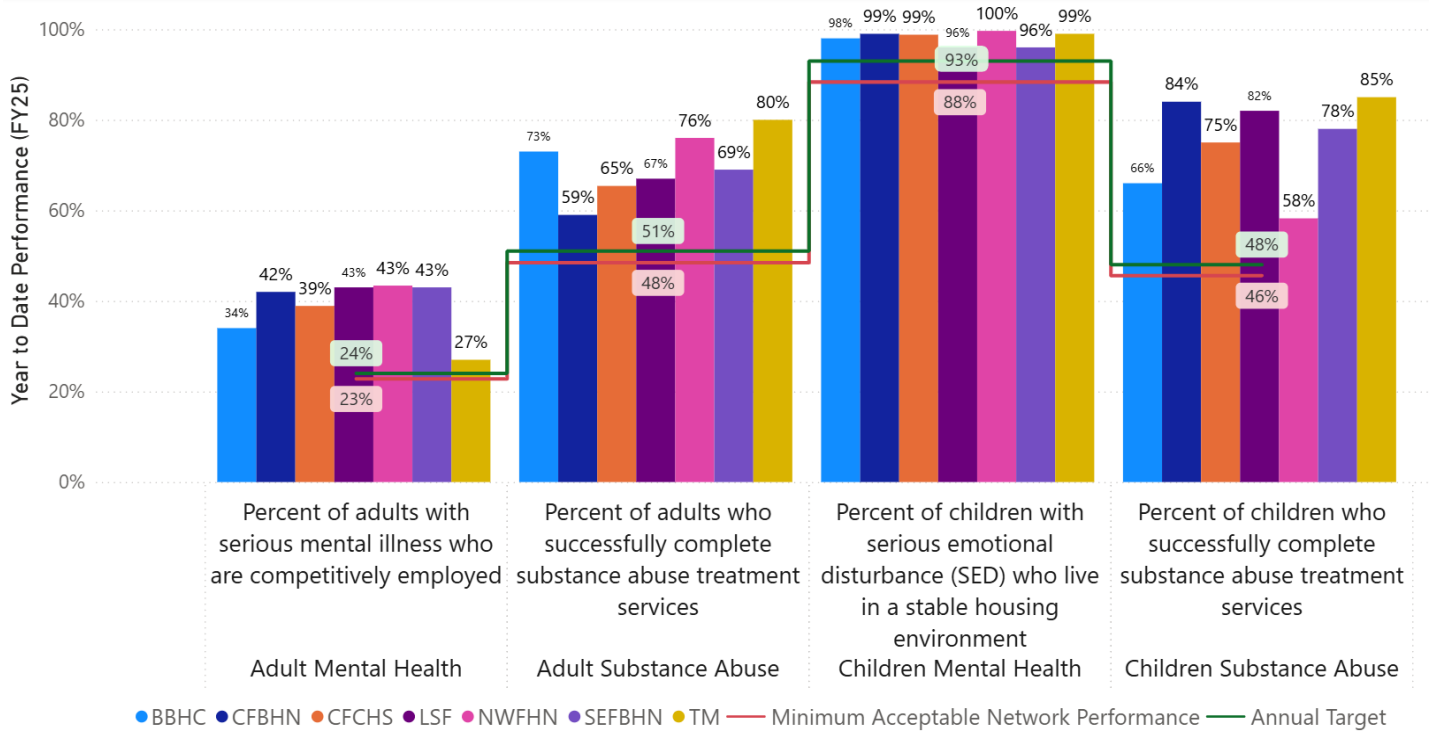
A summary of the observations from the template 11 testing can be found on the table subsequent to the charts section below.

Illustrations

FY2024 – Successful Completion of Program by ME

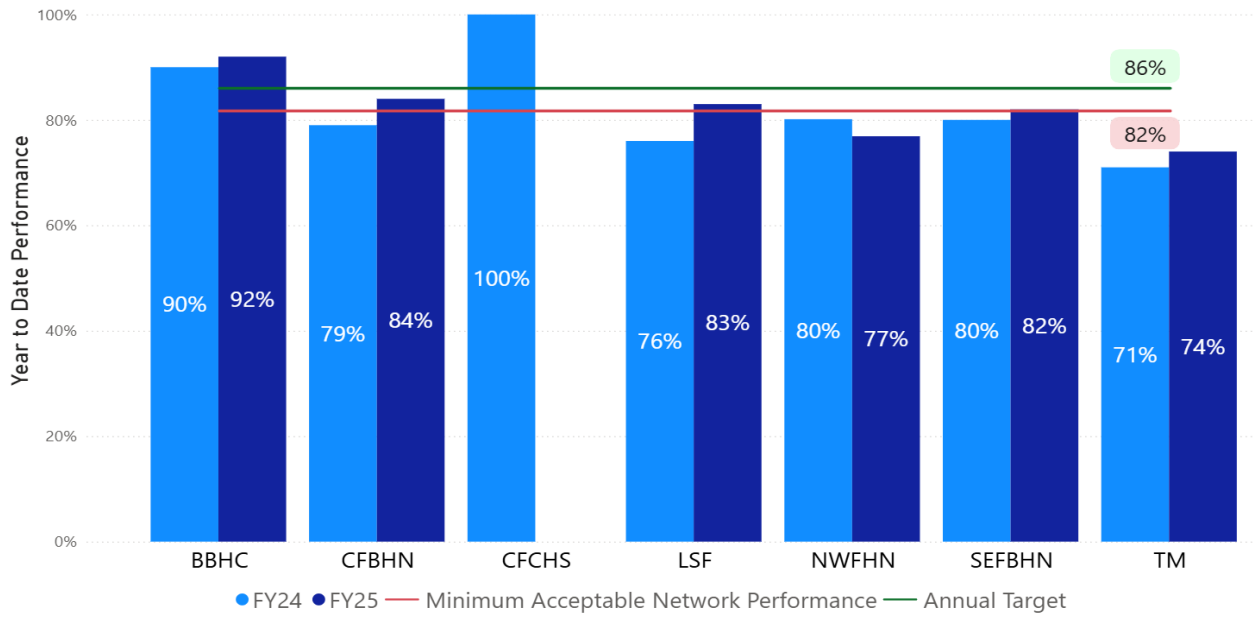


FY2025 – Successful Completion of Program by ME



Measures on Adult's Mental Health

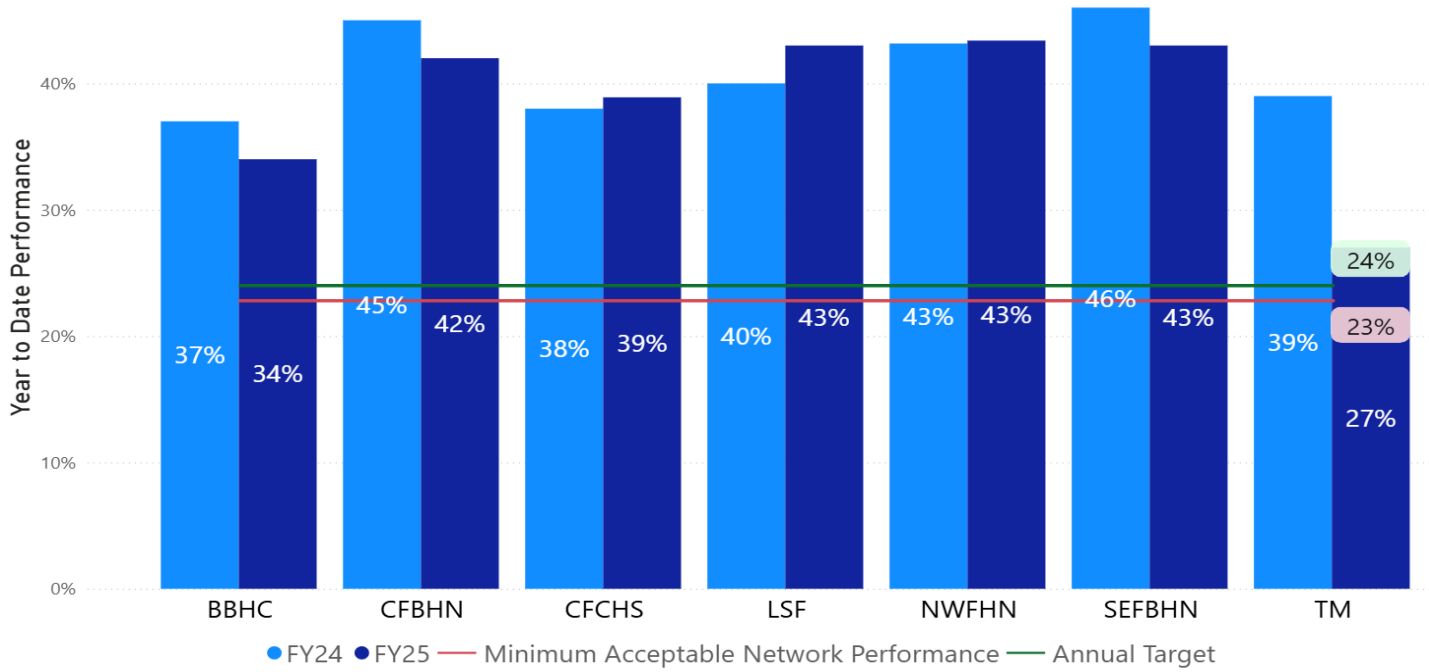
Percent of Adults in Mental Health Crisis Who Live in Stable Housing Environment by ME and Fiscal Year



- Many MEs did not reach the minimum target for stable housing for adults in mental health crisis.
- According to Florida Housing statistics*, shortages in housing and rising costs are statewide issues, and are likely drivers to the lack of success through the ME.

* florida-housing-data-project.reason.org/florida

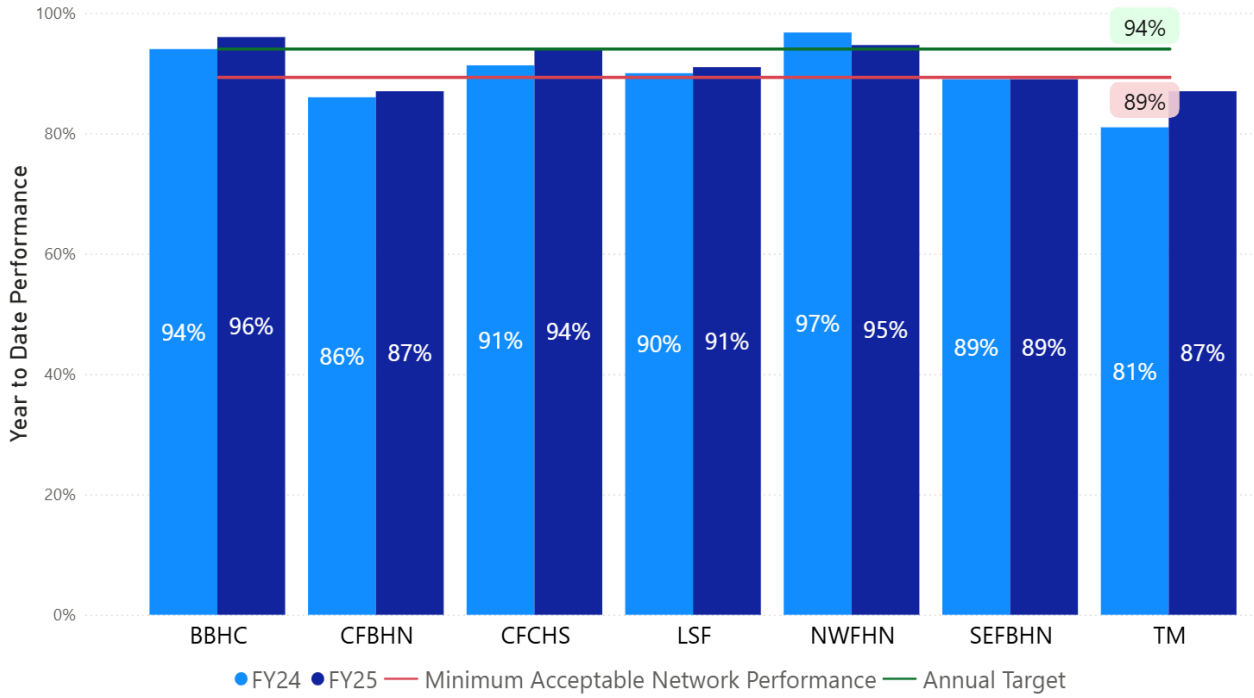
Percent of Adults with Serious Mental Illness Who are Competitively Employed by ME and Fiscal Year



- All MEs met or exceeded the annual targets for successful completion of substance abuse programs for adults.
- While there was a notable drop in percentage from 2024-2025 by Thriving Mind, they still met the annual target each year.

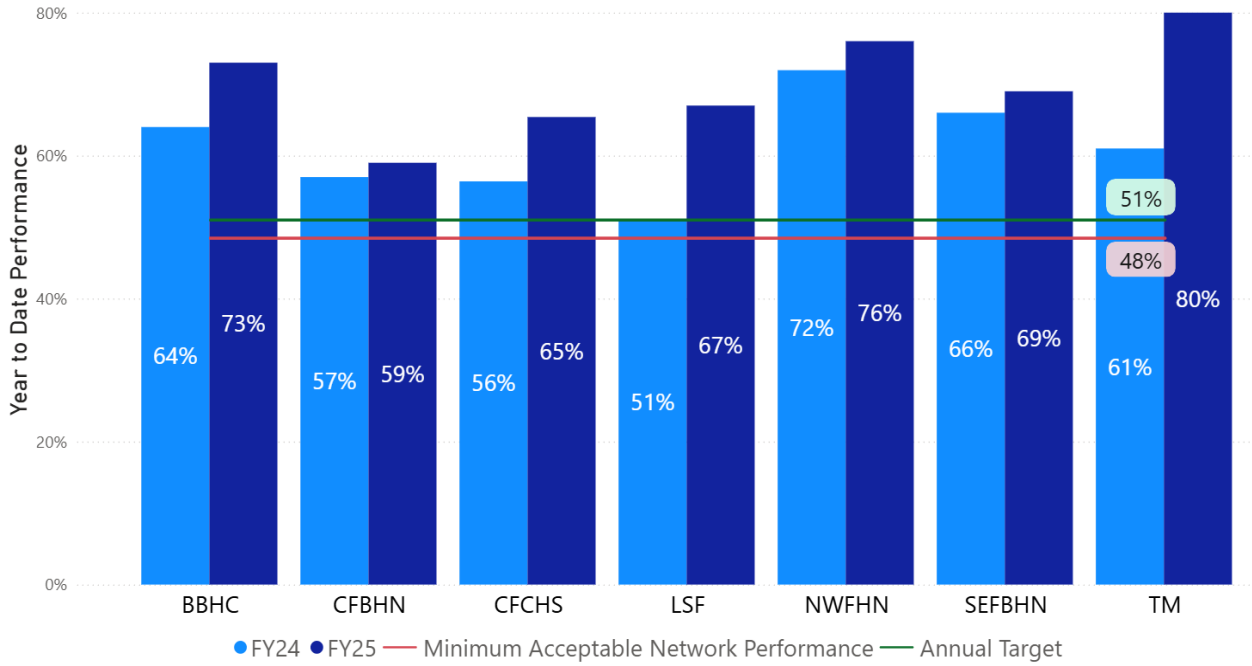
Measures on Adult's Substance Abuse

Percent of Adults with Substance Abuse Who Live in a Stable Housing Environment at the Time of Discharge by ME and Fiscal Year



- Central Florida Behavioral Health Network (CFBHN) and Thriving Mind (TM) did not meet the minimum expectation for stable housing measures at the time of discharge for adults.
- Thriving Mind (TM) reported county-wide housing shortages, as well as high medium costs for underlying problems contributing to the low results.

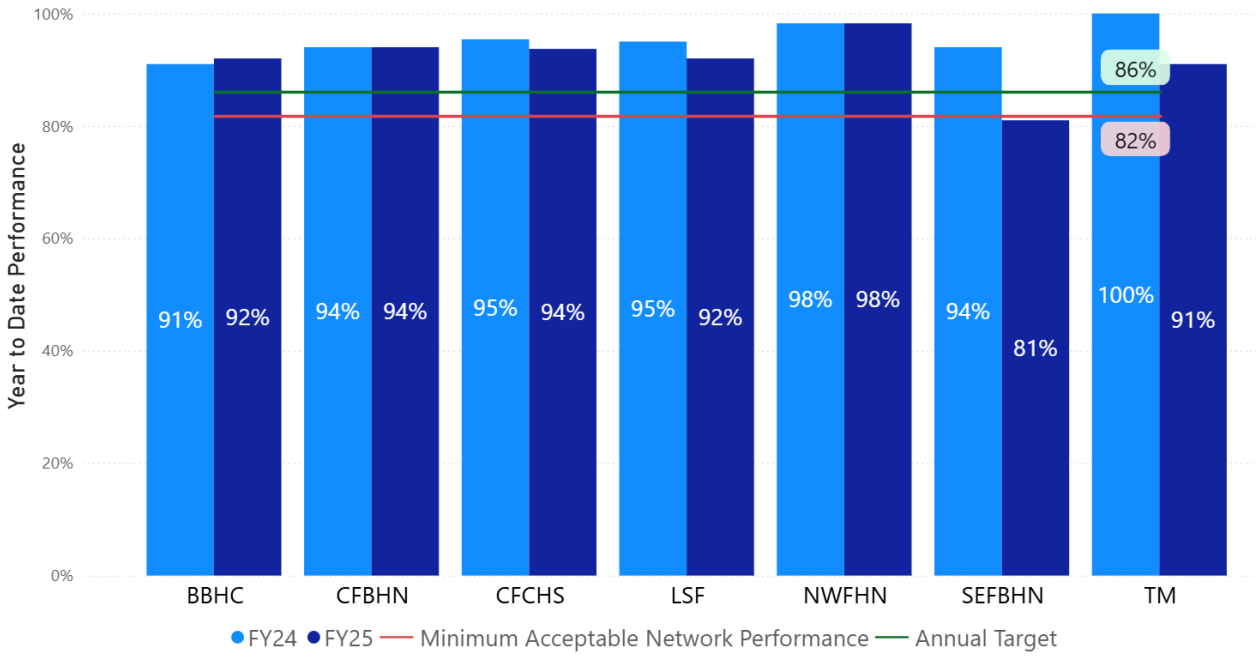
Percent of Adults Who Successfully Complete Substance Abuse Treatment Services by ME and Fiscal Year



- All MEs met or exceeded the annual targets for successful completion of substance abuse programs for adults.
- Thriving Mind (TM) and Lutheran Services Florida (LSF) made the most significant increases from 2024 to 2025.

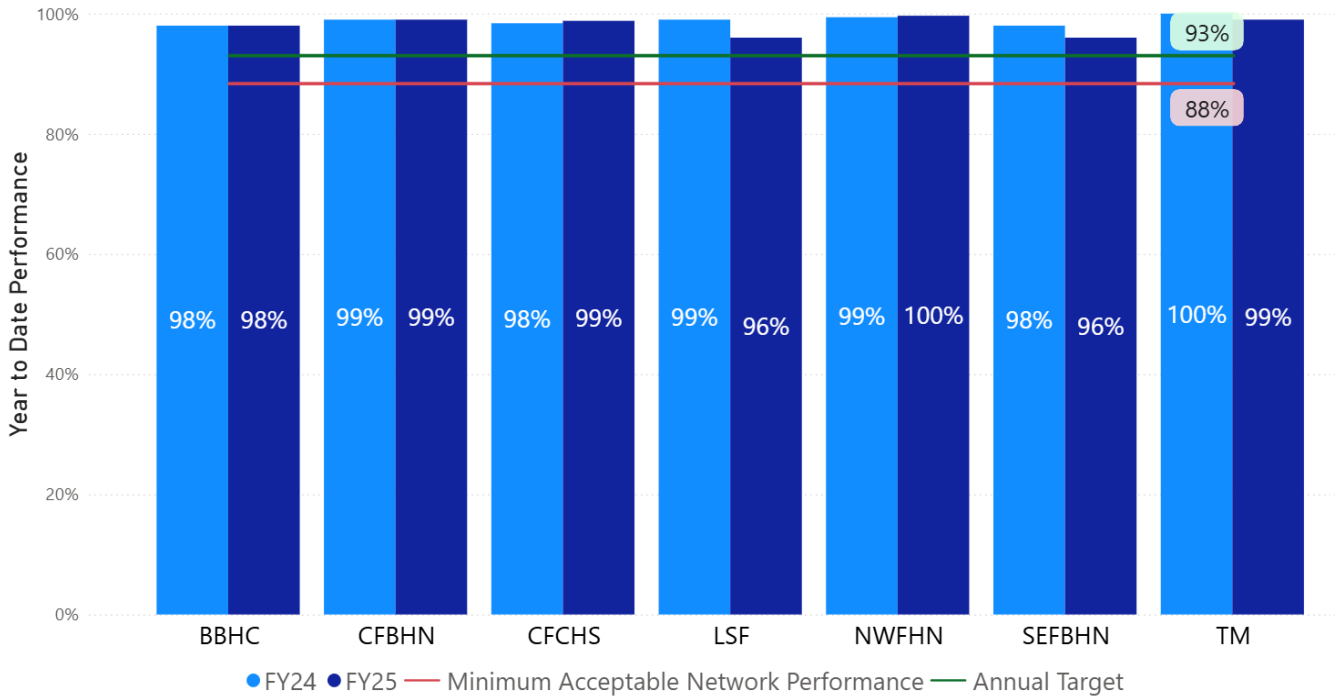
Measures on Children's Mental Health

Percent of School Days Serious Emotional Disturbance (SED) Children Attended by ME and Fiscal Year



- All MEs exceeded the annual targets for school days attended by children with Serious Emotional Disturbance (SED) except for Southeast Florida Behavioral Health Network (SEFBHN) in FY25.

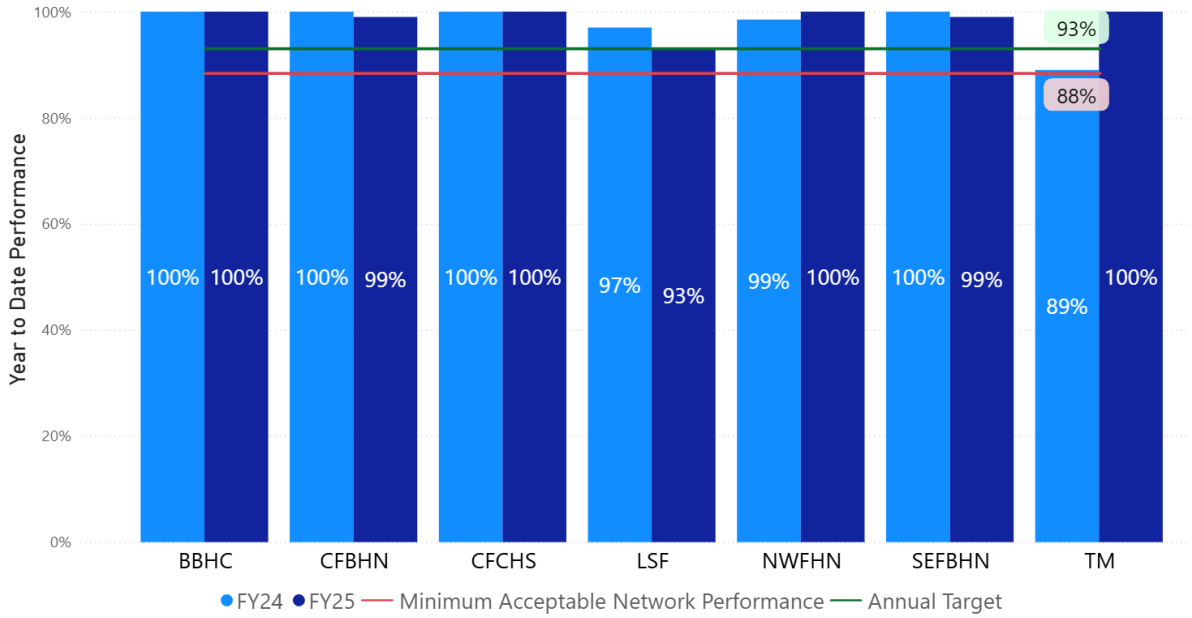
Percent of Children with Serious Emotional Disturbance (SED) Who Live in a Stable Housing Environment by ME and Fiscal Year



- All MEs exceeded the annual targets for stable housing for children with Serious Emotional Disturbance (SED).

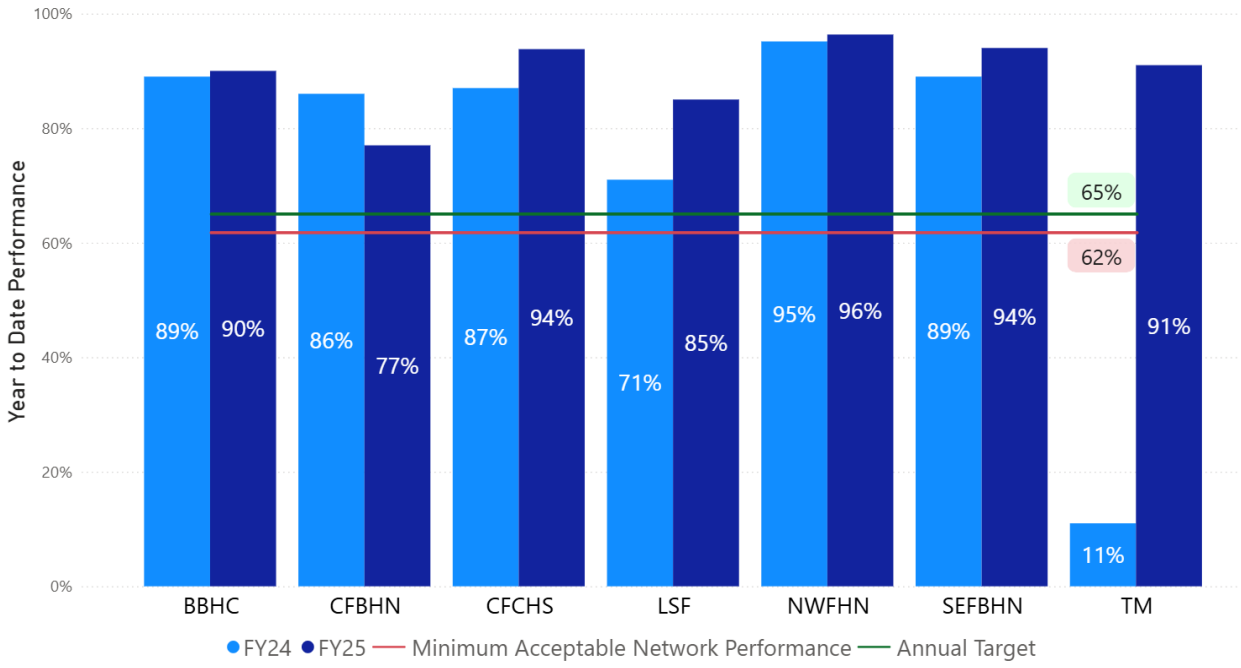
Measures on Children's Mental Health and Substance Abuse

Percent of Children with Substance Abuse Who Live in a Stable Housing Environment at the Time of Discharge by ME and Fiscal Year



- All MEs met or exceeded the annual targets for children with substance abuse who live in a stable environment.
- Thriving Mind (TM) made a notable improvement from FY24 to FY25.

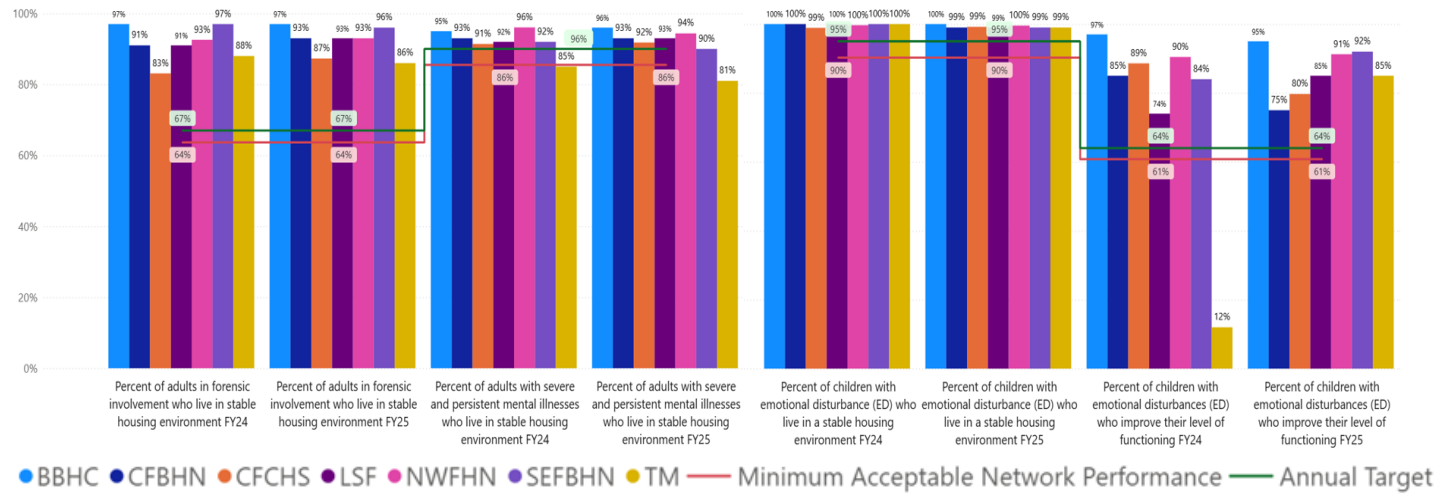
Percent of Children with Serious Emotional Disturbances (SED) Who Improve Their Level of Functioning by ME and Fiscal Year



- All MEs met or exceeded the annual targets in FY25 for Percentage of Children with Serious Emotional Disturbance (SED) who improved their level of functioning
- In FY24, Thriving Mind (TM) noted possible data reporting inaccuracies by service providers, as well as other systemic conditions impacting performance, and in FY25 they made a remarkable improvement by 80% and exceeded the annual target

Remaining ME Process Measures

A



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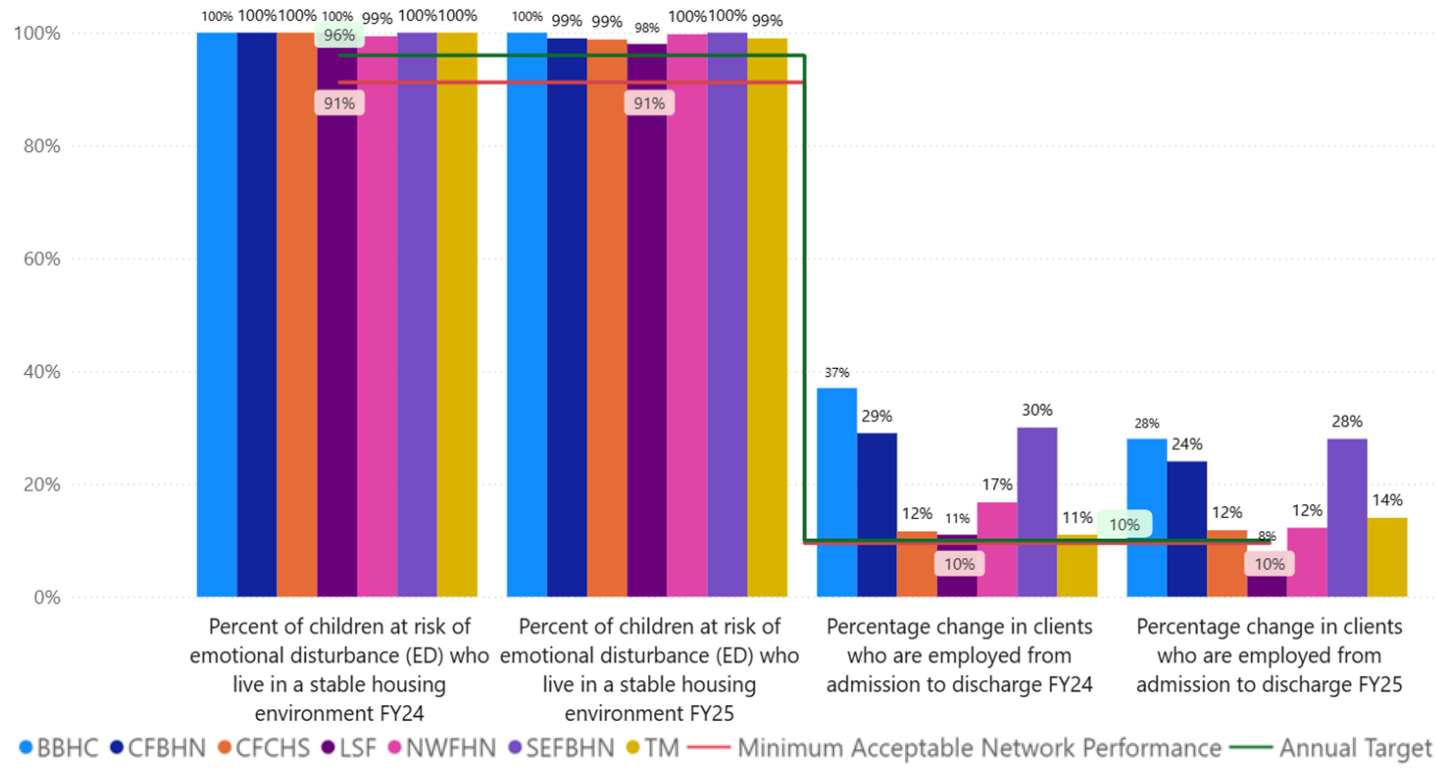
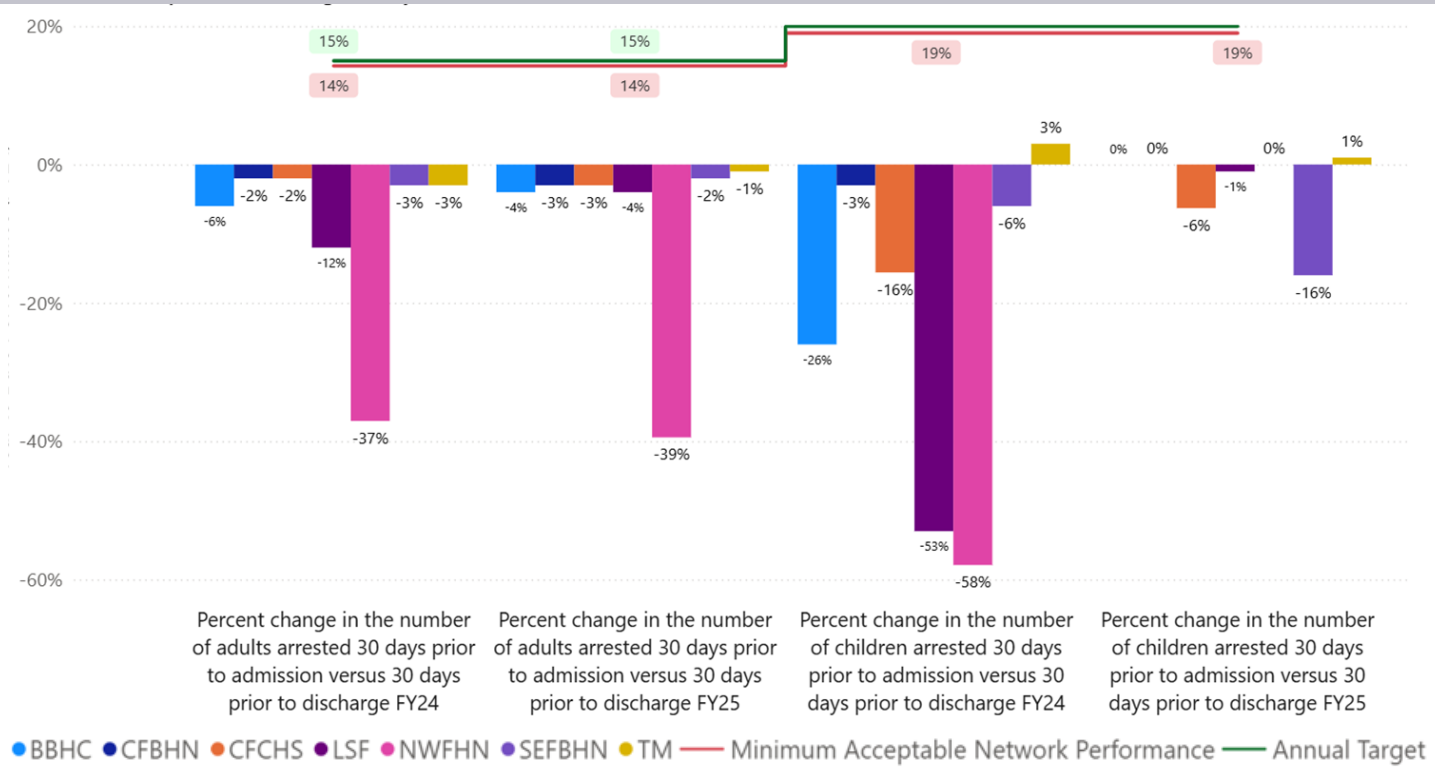


Remaining ME Process Measures

C



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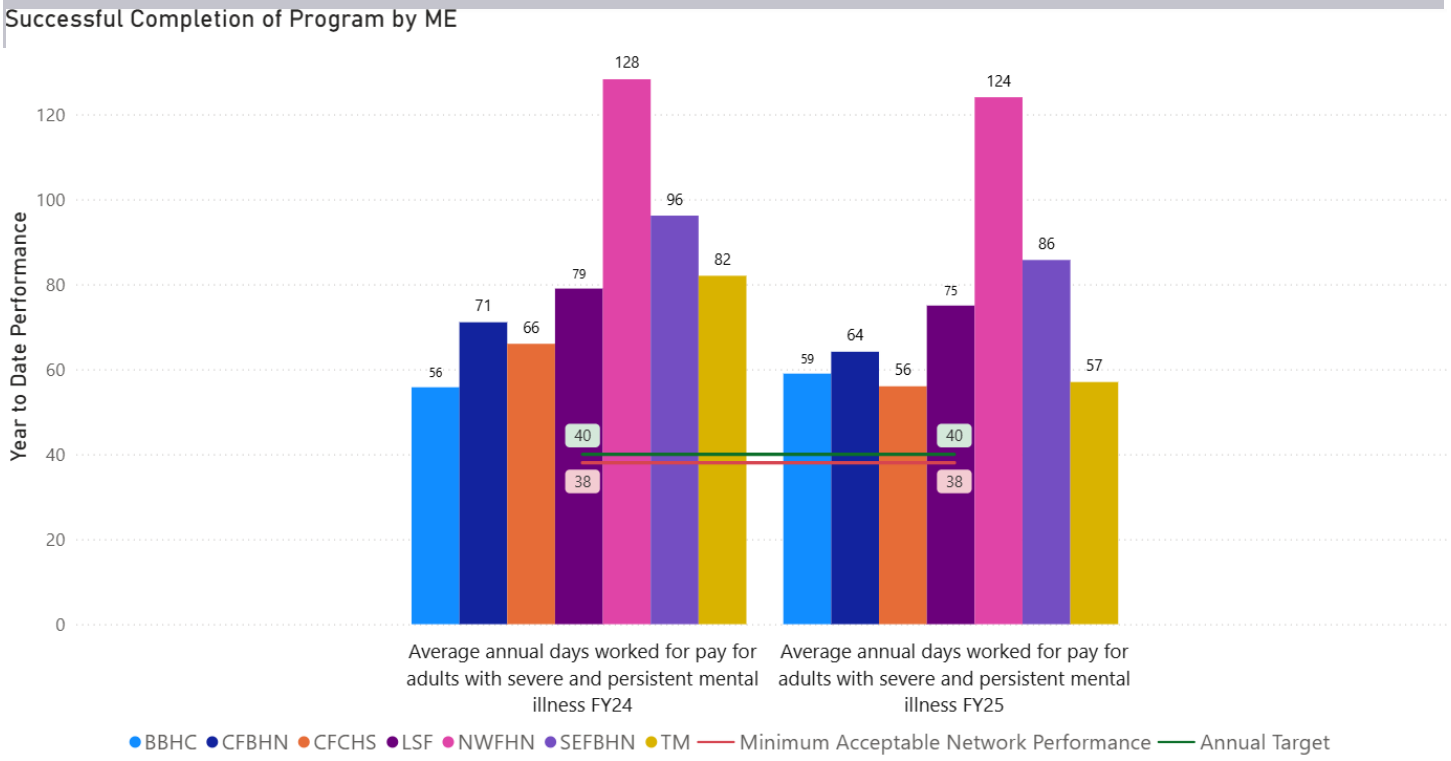

Template 11 Observations Overview and ME Responses

Managing Entity	Template 11 Metric Performance	ME Response
BBHC	The managing entity met/exceeded the "minimum acceptable network performance" and/or the "annual target" for all metrics across FY2024-FY2025 • % change in arrests 30 days prior to admission versus 30 days prior to discharge, FY2024 and FY2025 • Minimum Performance metric is 14.3% for adults and 20% for children, however, this should be interpreted as the absolute value of a negative percent change (reduction in arrests)	ME reports that they met all metrics across FY2024-FY2025.
SEFBHN	The managing entity met/exceeded the "minimum acceptable network performance" and/or the "annual target" for all metrics across FY2024-FY2025, except for: • % of adults in mental health crisis living in stable housing environment, FY2024 • % of school days seriously emotionally disturbed children attended, FY2025	ME reports that they met all measures, but the discrepancy was due to a rounding/formatting error (81.7% vs. 81.0%).
TMSF	The managing entity met/exceeded the "minimum acceptable network performance" and/or the "annual target" for all metrics across FY2024-FY2025, except for: • % of adults in mental health crisis living in stable housing environment, FY2024 and FY2025 • % of adults with substance abuse living in stable housing environment, FY2024 and FY2025 • % of children with serious emotional disturbances who improve their level of functioning, FY2024	ME reports continued difficulty meeting housing measures due to high home prices and shortage of rental units across Miami-Dade and Monroe counties. ME reports data entry errors by service providers and adoption of GFI scoring in FASAMS as potential contributors that impact performance. ME plans to continue to monitor underlying data. Lack of validation over NSP submitted metrics/outcomes.
NWFHN	The managing entity met/exceeded the "minimum acceptable network performance" and/or the "annual target" for all metrics across FY2024-FY2025, except for: • % of adults in mental health crisis living in stable housing environment, FY2024	No response requested at time of report – ME would be encouraged to share details of plan to monitor/alleviate housing difficulties.
CFBHN	The managing entity met/exceeded the "minimum acceptable network performance" and/or the "annual target" for all metrics across FY2024-FY2025, except for: • % of adults in mental health crisis living in stable housing environment, FY2024 • % of adults with substance abuse living in stable housing environment at time of discharge, FY2024 and FY2025	ME reports Carisk is meeting with each of the acute care providers to review data submission, ensure integrity, and will continue this process iteratively until data submission is complete and accurate. ME reports many providers were using other housing as an option for recovery homes which is not a stable housing location, therefore not contributing positively towards the metric. The housing crisis has caused the rates even in recovery homes to be drastically increased. With the additional requirement on recovery homes and the increase in cost it is hard to place individual long term in

Managing Entity	Template 11 Metric Performance	ME Response
		these types of supportive placements.
LSF	The managing entity met/exceeded the “minimum acceptable network performance” and/or the “annual target” for all metrics across FY2024-FY2025, except for: • % of adults in mental health crisis living in stable housing environment, FY2024	ME reports housing as a persistent problem outside of their control, exacerbated by the lack of available affordable housing. They do not submit a monthly report on this as but have historically discussed it at meetings with DCF contract manager.
CFCHS	The managing entity met/exceeded the “minimum acceptable network performance” and/or the “annual target” for all metrics across FY2024-FY2025, except for: • % of adults in mental health crisis living in stable housing environment, not reported in FY2025	Data volumes through most of 2024 were low due to EHR migrations for two large community mental health centers. Great progress has been made during the year and most of the data has been caught up, though there is still some missing data. These providers have been directed to continue submitting data for FY 2023-FY 2024 until they have fully caught up with their submissions. The AMH Crisis Stable Housed tends to only have individuals with co-occurring SUD and MH issues, but with a missing MH diagnosis. The providers that usually submit this data have been given the details to of the individuals contributing to the measure so they can make corrections, and it is my expectation that this measure will not have anyone contributing once that data correction is completed.

Glossary

Acronym	Description
AICPA	American Institute of Certified Public Accountants
BBHC	Broward Behavioral Health Coalition
CFBHN	Central Florida Behavioral Health Network
CFC	Central Florida Cares Health System
COSO	Committee of Sponsoring Organizations of the Treadway Commission
IIA	Institute of Internal Auditors
LSF	Lutheran Services Florida
MUS	Monetary Unit Sampling
NWFHN	Northwest Florida Health Network
PBC	Prepared by Client
RO	Reporting Organization
SEFBHN	Southeast Florida Behavioral Health Network
SME	Subject Matter Expert
SMR	Subject Matter Resource
TMSF	Thriving Mind South Florida
FWA	Fraud, Waste and Abuse

Terminology	Description
Controls Testing	Evaluation of the design and operating effectiveness of internal controls in preventing or detecting and correcting errors.
Substantive Testing	Detailed procedures used during the audit to evidence whether details and/or transactions are valid, accurate, and have occurred supporting by documentation.
Substantive Analytical Procedures	Evaluations of information utilizing both financial and non-financial data by performing data analysis over such.
Inherent Risk	The natural risk that exists before considering controls/measures in place to mitigate risks. This type of risk cannot be adjusted as a result of auditor or entity actions and includes the susceptibility of financial statement line items to result in misstatements.
Residual Risk	The risk that remains after controls have been implemented to address existing risks.