The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Appropriations

BILL:	CS/CS/SB 1440
INTRODUCER:	Appropriations Committee; Children, Families, and Elder Affairs Committee; and Senators Powell and Rouson
SUBJECT:	Children's Mental Health
DATE:	March 5, 2020 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Delia	Hendon	CF	**Fav/CS**
2.	Sneed	Kidd	AHS	**Recommend: Favorable**
3.	Sneed	Kynoch	AP	**Fav/CS**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CSCS/SB 1440 requires the Department of Children and Families (DCF) and the Agency for Health Care Administration (AHCA) to identify children, adolescents, and young adults age 25 and under, who are the highest users of crisis stabilization services and collaboratively take action to meet the behavioral health needs of such children. The bill directs these agencies to jointly submit a quarterly report to the Legislature during Fiscal Years 2020-2021 and 2021-2022 on the actions taken by both agencies to better serve these individuals.

The bill requires the behavioral health managing entities (MEs) to develop a plan that promotes the development and implementation of a coordinated system of care for children, adolescents, and young adults to integrate behavioral health services provided through state-funded child serving systems, to facilitate access to mental health and substance abuse treatment and services. The bill requires the DCF to contract with the MEs for crisis response services provided through mobile response teams (MRTs) to provide immediate, onsite behavioral health services 24 hours per day, seven days per week with onsite response time of 60 minutes from the time the request for services is made.

In order to procure contracts with MRTs, the MEs must collaborate with local sheriff's offices and public schools in the selection process. The bill also requires that the provider establish response protocols with local law enforcement agencies, community-based care (CBC) lead agencies, the child welfare system, and the Department of Juvenile Justice (DJJ), and requires

access to psychiatrists or psychiatric nurse practitioners, and requires MRTs to refer children, adolescents, or young adults and their families to an array of crisis response services that address their individual needs.

The bill requires the ME to promote the use of available crisis intervention services by requiring contracted providers to provide to parents and caregivers who receive safety-net behavioral health services with MRT contact information.

The bill amends foster parent preservice training requirements to include local MRT contact information and requires community-based care (CBC) lead agencies to provide MRT contact information to all individuals that provide care for dependent children.

The bill requires the DCF and the AHCA to assess the quality of care provided in crisis stabilization units to children and adolescents who are high utilizers of such services and submit a joint report to the Governor and Legislature. The bill also requires the AHCA to regularly test managed care plan provider network databases to ensure that behavioral health providers are accepting enrollees and confirm that enrollees have access to behavioral health systems.

The bill has an indeterminate, but likely insignificant, fiscal impact on state expenditures. See Section V.

The bill takes effect July 1, 2020.

II. Present Situation:

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

Behavioral Health Managing Entities

In 2001, the Legislature authorized the DCF to implement behavioral health managing entities (MEs) as the management structure for the delivery of local mental health and substance abuse services.[1] The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized the DCF to implement MEs statewide.[2] Full implementation of the statewide managing entity system occurred by April, 2013; all geographic regions are now served by a managing entity.[3]

The DCF contracts with seven MEs - Big Bend Community Based Care, Lutheran Services Florida, Central Florida Cares Health System, Central Florida Behavioral Health Network, Inc.,

[1] Chapter 2001-191, Laws of Fla.
[2] Chapter 2008-243, Laws of Fla.
[3] *The Department of Children and Families Performance and Accountability System for Behavioral Health Managing Entities*, Office of Program Policy Analysis and Government Accountability, July 18, 2014.

Southeast Florida Behavioral Health, Broward Behavioral Health Network, Inc., and South Florida Behavioral Health Network, Inc., that in turn contract with local service providers[4] for the delivery of mental health and substance abuse services:[5]

Baker Act

In 1971, the Legislature passed the Florida Mental Health Act (also known as "The Baker Act") to address the mental health needs of individuals in the state. The Baker Act allows for voluntary and, under certain circumstances, involuntary, examinations of individuals suspected of having a mental illness and presenting a threat of harm to themselves or others. The Baker Act also establishes procedures for courts, law enforcement, and certain health care practitioners to initiate such examinations and then act in response to the findings.

Individuals in acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[6] An involuntary examination is required if there is reason to believe that the person has a mental illness and because of his or her mental illness:[7]

- The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination or is unable to determine for himself or herself whether examination is necessary; and
- Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or
- There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

Involuntary Admissions

Involuntary patients must be taken to either a public or a private facility that has been designated by the Department of Children and Families (DCF) as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider.[8]

Within the 72-hour examination period, or if the 72 hours ends on a weekend or holiday, no later than the next business day, one of the following must occur:

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will assume custody;

[4] Managing entities create and manage provider networks by contracting with service providers for the delivery of substance abuse and mental health services.
[5] The Department of Children and Families, *Managing Entities*, https://www.myflfamilies.com/service-programs/samh/managing-entities/ (last visited Jan. 30, 2020).
[6] Sections 394.4625 and 394.463, F.S.
[7] Section 394.463(1), F.S.
[8] Section 394.455(39), F.S. This term does not include a county jail.

- The patient must be released for voluntary outpatient treatment;
- The patient, unless charged with a crime, must give express and informed consent to a placement as a voluntary and admitted as a voluntary patient; or
- A petition for involuntary placement must be filed in circuit court for involuntary outpatient or inpatient treatment.[9]

Receiving facilities must give prompt notice[10] of the whereabouts of a patient who is being involuntarily held for examination to the patient's guardian,[11] guardian advocate,[12] health care surrogate or proxy, attorney, and representative.[13] If the patient is a minor, the receiving facility must give prompt notice to the minor's parent, guardian, caregiver, or guardian advocate. Notice for an adult may be provided within 24 hours of arrival; however, notice for a minor must be provided immediately after the minor's arrival at the facility. The facility may delay the notification for a minor for up to 24 hours if it has submitted a report to the central abuse hotline. The receiving facility must attempt to notify the minor's parent, guardian, caregiver, or guardian advocate until it receives confirmation that the notice has been received. Attempts must be repeated at least once every hour during the first 12 hours after the minor's arrival and then once every 24 hours thereafter until confirmation is received, the minor is released, or a petition for involuntary services is filed with the court.[14]

Task Force Report on Involuntary Examination of Minors

In 2017, the Legislature created a task force within the DCF to address the issue of involuntary examination of minors ages 17 years old or younger. The task force was composed of stakeholders from the education, mental health, law enforcement, and legal fields. The task force reported its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives on November 15, 2017[15].

Analysis by the Task Force

Based on an analysis of available data regarding involuntary examinations of minors, the task force found that:[16]

- Involuntary examinations for children occur in varying degrees across counties.
- There is an increasing trend statewide and in certain counties to initiate involuntary examinations of minors.

[9] Section 394.463(2)(g), F.S.
[10] Notice may be provided in person or by telephone; however, in the case of a minor, notice may also be provided by other electronic means. *See* s. 394.455(2), F.S.
[11] "Guardian" means the natural guardian of a minor, or a person appointed by a court to act on behalf of a ward's person if the ward is a minor or has been adjudicated incapacitated. *See* s. 394.455(17), F.S.
[12] "Guardian advocate" means a person appointed by a court to make decisions regarding mental health treatment on behalf of a patient who has been found incompetent to consent to treatment. *See* s. 394.455(18), F.S.
[13] Section 394.4599(2)(b), F.S.
[14] Section 394.4599(c), F.S.
[15] The Department of Children and Families, Office of Substance Abuse and Mental Health, Task Force Report on Involuntary Examination of Minors, (Nov. 15, 2017), available at: http://www.dcf.state.fl.us/service-programs/samh/publications/ (last visited January 30, 2020).
[16] *Id.*

- The seasonal pattern shows that involuntary examinations are more common when school is in session.
- Some children have multiple involuntary examinations, although most children who have an involuntary examination have only one.
- Decreases in juvenile arrests correlate with increases of involuntary examinations of children, although it is important to note that the analyses did not show a causal link and there has been a long pattern of decreases in juvenile crime over more than a decade.
- While recent increases in involuntary examinations in certain counties are deserving of focus, a more important focus needs to be on counties that have high rates of involuntary examination. Counties with high rates are, for the most part, not the same counties with the recent increases.
- The most common involuntary examination for children is initiated by law enforcement based on evidence of harm to self.
- The majority of involuntary examinations initiated for children by mental health professionals are initiated by physicians, followed by licensed mental health counselors, and clinical social workers, with many fewer initiated by psychologists, psychiatric nurses, marriage and family therapists, and physicians' assistants.

Recommendations by the Task Force

The task force made six recommendations for encouraging alternatives to and eliminating inappropriate initiations of involuntary examinations of minors under the Baker Act:[17] The recommendations are:

- Fund an adequate network of prevention and early intervention services so that mental health challenges are addressed prior to becoming a crisis.
- Expand access to outpatient crisis intervention services and treatment.
- Create within the DCF the "Invest in the Mental Health of our Children" grant program to provide matching funds to counties that can be used to plan, implement, or expand initiatives that increase public safety, avert increased mental health spending, and improve the accessibility and effectiveness of prevention and intervention services for children who have a diagnosed mental illness or co-occurring mental health and substance use disorder.
- Encourage school districts, through legislative intent language, to adopt a standardized suicide assessment tool that school-based mental health professionals would implement prior to initiation of a Baker Act examination.[18]
- Revise s. 394.463, F.S., to include school psychologists licensed under ch. 490, F.S., on the list of mental health professionals who are qualified to initiate a Baker Act.
- Require Youth Mental Health First Aid or Crisis Intervention Team (CIT)[19] training for school resource officers and other law enforcement officers who initiate Baker Act examinations from schools.

[17] *Id.*

[18] The Task Force found that data supports the conclusion that implementation of risk assessment protocols significantly reduced the number of children and youth who received Baker Act initiations in school districts across the state.

[19] U.S. Department of Health and Human Services, *Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice: A Step-by-Step Guide*, 2018, available at: https://store.samhsa.gov/system/files/sma18-5065.pdf, states that: "CIT training is an effective law enforcement response program designed for first responders who handle crisis situations involving individuals with mental illness or co-occurring disorders. It emphasizes a partnership between law enforcement, the mental health and substance abuse treatment system, mental health advocacy groups, and consumers of mental health

Additionally, the task force recommended amending s. 394.463, F.S., to increase the timeframe from the next working day to five working days in which a receiving facility has to submit forms to the DCF required by s. 394.463, F.S. The task force determined that this change would allow the department to capture data on whether the minor was admitted, released, or a petition filed with the court.[20]

The DCF subsequently released an updated version of the report in 2019.[21] The report revealed that some crisis stabilization units are not meeting the needs of children and adolescents with significant behavioral health needs, contributing to multiple exams.

The 2019 report found there were 205,781 involuntary examinations in Fiscal Year 2017-2018, 36,078 of which were of minors.[22] From Fiscal Years 2013-2014 to 2017-2018, statewide involuntary examinations increased nearly 19 percent for children.[23] Children have a larger increase in examinations compared to young adults ages 18 to 24 (over 14 percent) and adults (over 12 percent).[24] Additionally, nearly 23 percent of minors had multiple involuntary examinations in Fiscal Year 2017-2018, ranging from 2 to 19 examinations.[25] The DCF identified 21 minors who had more than 10 involuntary examinations in Fiscal Year 2017-2018, with a combined total of 285 initiations.[26] The DCF's review of medical records found:[27]

- Most initiations were a result of minors harming themselves and were predominately initiated by law enforcement (88 percent);
- Many minors were involved in the child welfare system and most experienced significant family dysfunction;
- Most had Medicaid health insurance;
- Most experienced multiple traumas such as abuse, bullying, exposure to violence, parental incarceration, and parental substance abuse and mental health issues;
- Most had behavioral disorders of childhood, such as ADHD or Oppositional Defiant Disorder, followed by mood disorders, followed by anxiety disorders;
- Most involuntary examinations were initiated at home or at a behavioral health provider; and
- Discharge planning and care coordination by the receiving facilities was not adequate enough to meet the child's needs.

The 2019 report recommended:

- Increasing care coordination for minors with multiple involuntary examinations;

services and their families. Additionally, this training offers evidence-informed techniques designed to calm the individual in crisis down, reduces reliance on the Baker Act as a means of handling the crisis, and informs individuals of local resources that are available to people in need of mental health services and supports."

[20] *Id.*

[21] The Florida Department of Children and Families, Task Force Report on Involuntary Examination of Minors, 2019, (Nov. 2019), available at: https://www.myflfamilies.com/service-programs/samh/publications/ (last visited Jan. 31, 2020).

[22] *Id.*

[23] *Id.*

[24] *Id.*

[25] *Id.*

[26] *Id.*

[27] *Id.*

- Utilizing the wraparound care coordination approach for children with complex behavioral health needs and multi-system involvement to ensure one point of accountability and individualized care planning;
- Utilizing existing local review teams;
- Revising administrative rules to gather more information about actions taken after the initiation of exams, require electronic submission of forms, and improve care coordination and discharge planning;
- Funding an additional staff position in the DCF to provide technical assistance; and
- Ensuring that parents receive information about mobile crisis response teams and other community resources and supports upon child's discharge.

Mobile Response Teams

Mobile response teams (MRTs) provide readily available crisis care in a community-based setting and increase opportunities to stabilize individuals in the least restrictive setting to avoid the need for jail or hospital/emergency department utilization.[28] Early intervention services are critical to reducing involuntary examinations in minors and there are areas across the state where options short of involuntary examination via the Baker Act are limited or nonexistent. MRTs are available to individuals 25 years of age and under, regardless of their ability to pay, and must be ready to respond to any mental health emergency.[29] Telehealth can be used to provide direct services to individuals via video-conferencing systems, mobile phones, and remote monitoring. Telehealth can also be used to provide assessments and follow-up consultation as well as initial triage to determine if an in-person visit is needed to respond to the crisis call.[30]

In Fiscal Year 2018-2019, the Legislature funded additional mobile response teams to serve areas of the state that were not being served by such teams at a total cost of $18.3 million.[31] There are currently 40 MRTs serving all 67 Florida counties, targeting services to individuals ages 25 and under. Recent MRT monthly reports showed an 80 percent statewide average of diverting individuals from involuntary examination.[32]

The DCF established a framework to guide procurement of MRTs. This framework suggests that the procurement:

- Be conducted with the collaboration of local Sherriff's Offices and public schools in the procurement planning, development, evaluation, and selection process;
- Be designed to ensure reasonable access to services among all counties in the Managing Entity's service region, taking into consideration the geographic location of existing mobile crisis teams;
- Require services be available 24 hours per day, seven days per week with on-site response time to the location of referred crises within 60 minutes of the request for services;

[28] The Department of Children and Families, *Mobile Response Teams Framework*, (Aug. 29, 2018), p. 4, available at: https://www.myflfamilies.com/service-programs/samh/publications/docs/Mobile%20Response%20Framework.pdf (last visited Jan. 30, 2020).
[29] *Id.*
[30] *Id.*
[31] Chapter 2018-003, Laws of Fla.
[32] *Id.*

- Require the Network Service Provider to establish formalized written agreements to establish response protocols with local law enforcement agencies and local school districts or superintendents;
- Require access to a board-certified or board-eligible Psychiatrist or Psychiatric Nurse Practitioner; and
- Provide for an array of crisis response services that are responsive to the individual and family needs, including screening, standardized assessments, early identification, or linkage to community services as necessary to address the immediate crisis event.

III. Effect of Proposed Changes:

Section 1 amends s. 394.493, F.S., requiring the DCF and the AHCA to identify children and adolescents that are high utilizers of crisis stabilization services beginning in Fiscal Years 2020-2021 through 2021-2022. The bill requires both agencies to use this information to meet the behavioral health needs of these children within existing resources. The bill also requires the DCF and the AHCA to jointly submit quarterly reports to the Legislature listing the actions taken to address those needs.

Section 2 amends s. 394.495 F.S., requiring the DCF to contract with the MEs for crisis response services provided through MRTs throughout the state to provide immediate, onsite behavioral health services to children and young adults through age 25. The bill provides that mobile response services must be available to children and young adults:

- With an emotional disturbance;
- Experiencing an acute mental health or emotional crisis;
- Experiencing escalating emotional or behavioral [health] symptoms that effect their ability to function within their community; or
- Children served by the child welfare system experiencing placement instability.

The bill requires mobile response services to respond to new requests for services within 60 minutes in the location where the crisis is occurring. Services must be responsive to the needs of the child, young adult, and their family. Services must be evidence-based, enabling the individuals served to independently and effectively deescalate, reducing the possibility for future crises. MRT services must include screening, standardized assessment, and referral to community services and engage children, young adults, and their families as active participants in the process when possible. The bill also requires that MRT providers develop a care plan, provide care coordination by facilitating referrals to community-based services, establish a process for obtaining informed consent, promote information sharing and the use of innovative technology, coordinate with the ME and other service providers and interested parties including schools, the Multiagency Network for Students with Emotional/Behavioral Disabilities (SEDNET), the child welfare system, and the DJJ.

When procuring MRT providers under the bill, MEs must:

- Collaborate with local law enforcement agencies and public schools in the planning, development, evaluation and selection processes;
- Require that services must be available 24 hours a day, seven days a week, with onsite response time to the location of the crisis within 60 minutes;

- Require the MRT provider to establish protocols with law enforcement agencies, community-based care lead agencies (CBCs), the child welfare system, and the DJJ;
- Require access to a board certified or board eligible psychiatrist or psychiatric nurse practitioner; and
- Require MRTs to develop referral processes for individuals served to an array of crisis response services that address individual and family needs, including screening, standardized assessments, early identification, and community services to address the immediate crisis.

Section 3 creates s. 394.4955, F.S., requiring each ME to develop a plan that promotes the development and effective implementation of a coordinated system of care to integrate services provided and funded through the state child serving systems to facilitate access to needed mental health services. The development of the plan must include a planning process led by the ME and must include the DCF, individuals served and their families, behavioral health providers, law enforcement agencies, school districts or superintendents, the SEDNET, representatives from the child welfare system, the DJJ, early learning coalitions, the AHCA, the Agency for Persons with Disabilities, Medicaid managed medical assistance plans, and other community partners. The bill requires that during the planning process, the ME and the collaborating organizations consider the geographical distribution of the population, needs, and resources, and create separate plans for each county or multi-county area to maximize local collaboration and communication.

To the extent permitted by available resources, the local coordinated system of care must include the services listed in s. 394.495, F.S. The bill also requires each local plan to be integrated with the local designated receiving system plan developed under s. 394.4573, F.S., and must document each coordinated system of care through written memoranda of understanding or other binding arrangements. The ME and collaborating organizations must also create integrated service delivery approaches within current resources that facilitate parents and caregivers obtaining services and supports by making referrals to specialized treatment providers, if necessary, with follow-up to ensure services are received as part of the plan. MEs must complete plans by July 1, 2021, for submission to the DCF. The ME and collaborating organizations are required to implement the coordinated system of care as specified in the plan by July 1, 2022, and must review and update, as necessary, the plans every three years thereafter. When implementing the coordinated system of care, MEs must also identify gaps in the services arrays that are listed in s. 394.495, F.S., for each plan and include any relevant information in their needs assessment required by s. 394.9082, F.S.

Section 4 amends s. 394.9082, F.S., requiring the DCF to consider adolescents who require assistance in transitioning to services provided by the adult system of care when defining the priority populations that will benefit receiving care coordination. The bill requires MEs to include a list and descriptions of gaps in the array of services for children and adolescents identified pursuant to s. 394.4955, F.S., and recommendations for addressing these gaps. The bill also requires MEs to promote the use of available crisis intervention services by requiring contracted service providers to provide MRT contact information to parents and caregivers of children, adolescents, and young adults between ages 18 and 25, who receive safety-net behavioral health services.

Section 5 amends s. 409.175, F.S., requiring preservice training for foster parents to include information about the local MRT, including contact information, as a means for addressing any behavioral health crisis or to prevent placement disruption.

Section 6 amends s. 409.967, F.S., requiring the AHCA to conduct or contract for systematic and continuous testing of provider network databases maintained by managed care plans in order to confirm that behavioral health providers are accepting enrollees, and confirm that enrollees have access to behavioral health services.

Section 7 amends s. 409.988, F.S., requiring that the CBCs ensure that all individuals providing care for dependent children receive contact information for the local MRTs.

Section 8 amends s. 985.601, F.S., requiring the DJJ to participate in the planning process for promoting a coordinated system of care for children and adolescents established in section 3 of the bill.

Section 9 amends s. 1003.02, F.S., requiring district school boards to participate in the planning process for promoting a coordinated system of care for children and adolescents established in section 3 of the bill.

Section 10 amends s. 1004.44, F.S., requiring the Louis De La Parte Florida Mental Health Institute (FMHI)[33] within the University of South Florida, to develop a model response protocol for schools to utilize MRTs by August 1, 2020 and sets minimum requirements for the response protocol. The FMHI must consult with school districts that effectively work with MRTs, school districts that use MRTs less often, law enforcement agencies, the DCF, MEs, and MRT providers.

Section 11 amends s. 1006.04, F.S., requiring the SEDNET to participate in the planning process for promoting a coordinated system of care for children and adolescents as established in section 3 of the bill.

Section 12 requires the DCF and the AHCA to assess the quality of care provided in crisis stabilization units to children and adolescents who are high utilizers of services. The bill requires the DCF and the AHCA to review current laws regarding licensure and designation under s. 394.461, F.S., and compare standards to other states and national standards to make recommendations for improvements. This assessment shall address efforts by facilities to gather and assess information regarding the child or adolescent, to create comprehensive discharge plans to effectively address the needs of the child to help avoid or reduce the need for future crisis stabilization services.

The bill requires the DCF and the AHCA to jointly submit a report of the findings and recommendations to the Governor, the Senate President, and the Speaker of the House of Representatives by November 15, 2020.

[33] The Louis De La Parte Florida Mental Health Institute is housed within the College of Behavioral and Community Sciences at the University of South Florida. Available at: https://www.usf.edu/cbcs/fmhi/.

Section 13 provides an effective date of July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Private sector providers of behavioral health services for children, adolescents, and adults ages 25 and under, will need to revise policies and procedures, generate new forms, and provide training to service provider staff and administrators on the new requirements in the bill. Additional staff may be required for some providers to meet the increased need for services and revised patient response time requirements. The fiscal impact of these changes is indeterminate.

The additional responsibilities under the bill will create a significant fiscal impact for MRTs. Requiring services to be provided within 60 minutes of a request will be difficult to provide given the current strained capacity of MRTs and that MRTs often provide services remotely (via telehealth or other means of electronic communication). Additionally, there will be a significant fiscal impact to MRTs if the teams are responsible for on-going care. Currently, MRTs are responsible for the hand off and transition to ongoing behavioral health and wraparound services. The agency or agencies are responsible for providing ongoing services to ensure the active participation of parents and children and continued treatment.

C. Government Sector Impact:

Department of Children and Families

The DCF estimates that it will require one additional full-time employee (FTE) to carry out the duties of coordinating care for children and adolescents that are high utilizers of crisis stabilization services. The department estimates the recurring cost for the position to be $85,281 from the General Revenue Fund.[34] However, the department should be able to absorb the additional workload within existing department resources.

To the extent more children and their families are referred to behavioral health services, a managing entity may incur an administrative workload increase.

The Agency for Health Care Administration

The AHCA estimates that it will require two additional FTEs to implement the behavioral health network adequacy requirements and data analysis outline in the bill. The agency estimates that the two staff positions will result in recurring costs of $173,174 with $86,587 being funded from the General Revenue Fund. However, the department should be able to absorb the additional workload within existing department resources.

School Districts

The bill requires public schools to collaborate with MEs in the planning, development evaluation and selection of MRT service providers. The fiscal impact to the school districts is expected to be insignificant.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 394.493, 394.495, 394.9082, 409.175, 409.967, 409.988, 985.601, 1003.02, 1004.44, and 1006.04.

This bill creates section 394.4955 of the Florida Statutes.

[34] The Department of Children and Families Agency Analysis, HB 945, Dec. 19, 2019. On file with the Senate Children, Families, and Elder Affairs Committee.

IX. Additional Information:

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

CS/CS by Appropriations on March 3, 2020:
The committee substitute:

- Removes the requirement for school districts to:
  - Develop agreements with managing entities for the referral of students to community-based behavioral health providers in order to receive mental health assistance allocation funding.
  - Use the services of MRTs to the extent services are available.

CS by Children, Families, and Elder Affairs on February 4, 2020:

- Requires the AHCA to continually test the managed care plan provider network databases to ensure that behavioral health providers are accepting enrollees and confirm that enrollees have access to behavioral health systems.

B. Amendments:

None.