AN ACT CONCERNING CHILDREN’S MENTAL HEALTH.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (Effective from passage) The Commissioner of Public Health, in consultation with the Commissioner of Children and Families, shall develop and implement a plan to establish licensure by reciprocity or endorsement of a person who (1) is a mental or behavioral health care provider licensed or certified to provide mental or behavioral health care services, or is entitled to provide mental or behavioral health care services under a different designation, in another state having requirements for practicing in such capacity that are substantially similar to or higher than the requirements in force in this state, and (2) has no disciplinary action or unresolved complaint pending against such person. When developing and implementing such plan, the Commissioner of Public Health shall consider (A) eliminating barriers to the expedient licensure of such persons in order to immediately address the mental health needs of children in this state, and (B) whether such licensure should be limited to the provision of mental or behavioral health care services through the use of telehealth, as defined in section 19a-906 of the general statutes. The Commissioner of Public Health shall
prioritize establishing licensure by reciprocity or endorsement to a person who is a mental or behavioral health care provider licensed or certified to provide mental health care services to children, or is entitled to provide mental or behavioral health care services to children under a different designation. On or before January 1, 2023, the Commissioner of Public Health shall (i) implement the plan to establish licensure by reciprocity or endorsement, and (ii) report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and children regarding such plan and recommendations for any necessary legislative changes related to such plan.

Sec. 2. Section 20-195n of the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage):

(a) No person shall practice clinical social work unless such person has obtained a license pursuant to this section.

(b) An applicant for licensure as a master social worker shall: (1) Hold a master's degree from a social work program accredited by the Council on Social Work Education or, if educated outside the United States or its territories, have completed an educational program deemed equivalent by the council; and (2) pass the masters level examination of the Association of Social Work Boards or any other examination prescribed by the commissioner. On and after the effective date of this section, the commissioner may waive the examination requirement set forth in subdivision (2) of this subsection, as the commissioner deems necessary to ensure a sufficient number of licensed master social workers in the state, for an applicant who (A) is an English language learner and failed the examination required under subdivision (2) of this subsection, provided the applicant provides written certification to the commissioner of the applicant's intent to retake such examination not later than six months after last taking the examination or at the next offering of the examination, whichever is later, and (B) continues to be supervised by a licensed social worker when practicing professional
social work and submits to the department a signed document from the
applicant's supervising social worker granting the applicant permission
to seek a waiver of such examination requirement. The commissioner
may not waive such examination requirement for any applicant for
longer than one year.

(c) An applicant for licensure as a clinical social worker shall: (1) Hold
a doctorate or master's degree from a social work program accredited
by the Council on Social Work Education or, if educated outside the
United States or its territories, have completed an educational program
deemed equivalent by the council; (2) have three thousand hours post-
master's social work experience which shall include not less than one
hundred hours of work under professional supervision by a licensed
clinical or certified independent social worker, provided on and after
October 1, 2011, such hours completed in this state shall be as a licensed
master social worker; and (3) pass the clinical level examination of the
Association of Social Work Boards or any other examination prescribed
by the commissioner. On and after October 1, 1995, any person certified
as an independent social worker prior to October 1, 1995, shall be
deemed licensed as a clinical social worker pursuant to this section,
except a person certified as an independent social worker on and after
October 1, 1990, shall not be deemed licensed as a clinical social worker
pursuant to this chapter unless such person has satisfied the
requirements of subdivision (3) of this subsection. On and after the
effective date of this section, the commissioner may waive the
examination requirement set forth in subdivision (3) of this subsection,
as the commissioner deems necessary to ensure a sufficient number of
licensed master social workers in the state, for an applicant who (A) is
an English language learner and failed the examination required under
subdivision (3) of this subsection, provided the applicant provides
written certification to the commissioner of the applicant's intent to
retake such examination not later than six months after last taking the
examination or at the next offering of the examination, whichever is
later, and (B) continues to be supervised by a licensed social worker
when practicing professional social work and submits to the department
a signed document from the applicant's supervising social worker.
granting the applicant permission to seek a waiver of such examination requirement. The commissioner may not waive such examination requirement for any applicant for longer than one year.

(d) Notwithstanding the provisions of subsection (b) of this section, the commissioner may grant a license by endorsement to an applicant who presents evidence satisfactory to the commissioner that the applicant (1) is licensed or certified as a master social worker or clinical social worker in good standing in another state or jurisdiction whose requirements for practicing in such capacity are substantially similar to or higher than those of this state, and (2) has successfully completed the master level examination of the Association of Social Work Boards, or its successor organization, or any other examination prescribed by the commissioner. On and after the effective date of this section, the commissioner may waive the examination requirement set forth in subdivision (2) of this subsection, as the commissioner deems necessary to ensure a sufficient number of licensed master social workers in the state, for an applicant who (A) is an English language learner and failed the examination required under subdivision (2) of this subsection, provided the applicant provides written certification to the commissioner of the applicant's intent to retake such examination not later than six months after last taking the examination or at the next offering of the examination, whichever is later, and (B) continues to be supervised by a licensed social worker when practicing professional social work and submits to the department a signed document from the applicant's supervising social worker granting the applicant permission to seek a waiver of such examination requirement. The commissioner may not waive such examination requirement for any applicant for longer than one year. No license shall be issued under this subsection to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.

(e) Notwithstanding the provisions of subsection (c) of this section, the commissioner may grant a license by endorsement to an applicant who presents evidence satisfactory to the commissioner that the applicant (1) is licensed or certified as a clinical social worker in good
standing in another state or jurisdiction whose requirements for practicing in such capacity are substantially similar to or greater than those of this state, and (2) has successfully completed the clinical level examination of the Association of Social Work Boards, or its successor organization, or any other examination prescribed by the commissioner. On and after the effective date of this section, the commissioner may waive the examination requirement set forth in subdivision (2) of this subsection, as the commissioner deems necessary to ensure a sufficient number of licensed master social workers in the state, for an applicant who (A) is an English language learner and failed the examination required under subdivision (2) of this subsection, provided the applicant provides written certification to the commissioner of the applicant's intent to retake such examination not later than six months after last taking the examination or at the next offering of the examination, whichever is later, and (B) continues to be supervised by a licensed social worker when practicing professional social work and submits to the department a signed document from the applicant's supervising social worker granting the applicant permission to seek a waiver of such examination requirement. The commissioner may not waive such examination requirement for any applicant for longer than one year. No license shall be issued under this subsection to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.

(f) Notwithstanding the provisions of this section, an applicant who is licensed or certified as a clinical social worker or its equivalent in another state, territory or commonwealth of the United States may substitute three years of licensed or certified work experience in the practice of clinical social work in lieu of the requirements of subdivision (2) of subsection (c) of this section, provided the commissioner finds that such experience is equal to or greater than the requirements of this state.

(g) The commissioner shall notify every applicant who is taking an examination required under subsection (b), (c), (d) or (e) of this section that they may use a dictionary while taking the examination.
Sec. 3. Section 20-195t of the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage):

The department may issue a temporary permit to an applicant for licensure as a master social worker who holds a master's degree from a social work educational program, as described in section 20-195n, but who has not yet taken the licensure examination prescribed in said section 20-195n. Such temporary permit shall authorize the holder to practice as a master social worker as provided for in section 20-195s.

Such temporary permit shall be valid for a period not to exceed one year after the date of attaining such master's degree and shall not be renewable. On and after July 1, 2024, such temporary permit shall be valid for a period not to exceed one hundred twenty calendar days after the date of attaining such master's degree and shall not be renewable. Such permit shall become void and shall not be reissued in the event that the applicant fails to pass such examination. The fee for a temporary permit shall be fifty dollars.

Sec. 4. (NEW) (Effective October 1, 2022) (a) The Commissioner of Public Health shall establish a social workers examination preparation grant program to provide grants to social workers for the costs of tutoring and examination preparation courses for applicants for licensure as a master social worker who are preparing for the masters level examination of the Association of Social Work Boards, or any other examination prescribed by the commissioner, and for candidates for licensure as a clinical social worker who are preparing for the clinical level examination of said association, or any other examination prescribed by the commissioner, including, but not limited to, the costs of an interpreter for any applicant who is an English language learner.

(b) The commissioner shall establish guidelines for the administration of such grant program.

Sec. 5. (NEW) (Effective from passage) (a) The Commissioner of Public Health, in consultation with the Commissioner of Children and Families, shall establish a scholarship program for applicants for licensure in professions that serve the mental or behavioral health needs
of children in the state.

(b) Within available appropriations, the program shall provide need-based scholarships for persons applying to the Department of Public Health for licensure in professions that serve the mental or behavioral health needs of children in the state. The scholarship shall not exceed the combined costs of application and licensure fees. The Commissioner of Public Health shall develop eligibility requirements for recipients and give priority to applicants (1) who are a member of a racial or ethnic minority, (2) for whom English is a second language, (3) who identify as lesbian, gay, bisexual, transgender or queer, or (4) who are a person with a disability. A person may apply for such scholarship to the Department of Public Health at such time and in such manner as the Commissioner of Public Health prescribes.

(c) The Department of Public Health may accept private donations for such scholarship program.

(d) Any unexpended funds appropriated for purposes of this section shall not lapse at the end of the fiscal year but shall be available for expenditure during the next fiscal year.

(e) For the fiscal year ending June 30, 2022, and each fiscal year thereafter, the Commissioner of Public Health may use up to five percent of the funds appropriated for purposes of this section for program administration, promotion, recruitment and retention activities.

(f) On or before January 1, 2023, and annually thereafter, the Commissioner of Public Health shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding (1) the number of recipients and demographics of such recipients of the scholarship program established under this section and, where available, the demographics of the persons served by such recipients in such recipients' professional capacities, and (2) a detailed description of how the Department of Public Health utilizes the money allocated for administration of the
scholarship program.

Sec. 6. Subsection (b) of section 17a-22ff of the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2022):

(b) The board shall consist of the following members:

(1) Eight appointed by the Commissioner of Children and Families, who shall represent families of children who have been diagnosed with mental, emotional or behavioral health issues;

(2) Two appointed by the Commissioner of Children and Families, who shall represent a private foundation providing mental, emotional or behavioral health care services for children and families in the state;

(3) Four appointed by the Commissioner of Children and Families, who shall be providers of mental, emotional or behavioral health care services for children in the state, at least one of whom shall be a provider of services to children involved with the juvenile justice system;

(4) Three appointed by the Commissioner of Children and Families, who shall represent private advocacy groups that provide services for children and families in the state;

(5) One appointed by the Commissioner of Children and Families, who shall represent the United Way of Connecticut 2-1-1 Infoline program;

(6) One appointed by the majority leader of the House of Representatives, who shall be a medical doctor representing the Connecticut Children's Medical Center Emergency Department;

(7) One appointed by the majority leader of the Senate, who shall be a superintendent of schools in the state;

(8) One appointed by the minority leader of the House of Representatives, who shall represent the Connecticut Behavioral Healthcare Partnership;
(9) One appointed by the minority leader of the Senate who shall represent the Connecticut Association of School-Based Health Centers;

(10) The Commissioner of Children and Families, or the commissioner's designee;

(11) The Commissioner of Developmental Services, or the commissioner's designee;

(12) The Commissioner of Social Services, or the commissioner's designee;

(13) The Commissioner of Public Health, or the commissioner's designee;

(14) The Commissioner of Mental Health and Addiction Services, or the commissioner's designee;

(15) The Commissioner of Education, or the commissioner's designee;

(16) The Commissioner of Early Childhood, or the commissioner's designee;

(17) The Insurance Commissioner, or the commissioner's designee;

(18) The Labor Commissioner, or the commissioner's designee;

(19) The Secretary of the Office of Policy and Management, or the secretary's designee;

(20) The Commissioner of Correction, or the commissioner's designee;

[(18)] (21) The executive director of the Court Support Services Division of the Judicial Branch, or the executive director's designee;

[(19)] (22) The Child Advocate, or the Child Advocate's designee;

[(20)] (23) The Healthcare Advocate, or the Healthcare Advocate's designee; [and]
The executive director of the Commission on Women, Children, Seniors, Equity and Opportunity, or the executive director's designee; [.]

(25) One representative of the Governor's office;

(26) Two representatives of commercial health insurance carriers;

(27) One representative of the Commission on Racial Equity in Public Health established pursuant to public act 21-35;

(28) One representative of the Commission on the Disparate Impact of COVID-19 established pursuant to special act 21-37;

(29) One representative of the task force created pursuant to public act 21-125 concerning mental health service provider networks; and

(30) One representative of the task force on children's needs created pursuant to public act 21-46.

Sec. 7. (NEW) (Effective July 1, 2022) On or before January 1, 2023, the Department of Children and Families shall establish and administer a data repository for (1) emergency mobile psychiatric services personnel to share best practices and experiences while providing emergency mobile psychiatric services in the field, and (2) emergency mobile psychiatric services personnel and the department to, when available and appropriate, collect data on outcomes of patients who received emergency mobile psychiatric services, which data shall be deidentified and disaggregated, for internal quality improvement purposes.

Sec. 8. (NEW) (Effective October 1, 2022) (a) There is established in the city of Waterbury a pilot program to allow a hospital to administer a partial hospitalization program and an intensive outpatient program, for adolescents with mental or behavioral health issues. As used in this subsection, "partial hospitalization program" means a structured program of outpatient psychiatric services as an alternative to inpatient psychiatric care.
(b) Not later than January 1, 2024, and annually thereafter, the Commissioner of Public Health, in consultation with the Commissioners of Children and Families and Mental Health and Addiction Services, shall report, in accordance with the provisions of section 11-4a of the general statutes, regarding the implementation of the pilot program to the joint standing committees of the General Assembly having cognizance of matters relating to public health and children. Such report shall assess the effectiveness of the pilot program and include legislative recommendations concerning implementation of the pilot program on a state-wide basis.

Sec. 9. Section 17a-20a of the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage):

(a) [Not later than January 1, 2014, the] The Commissioner of Children and Families shall establish and implement a regional behavioral health consultation and care coordination program for (1) primary care providers who serve children, and (2) the pediatric patients of such providers. Such program shall provide to such primary care providers [: (1) Timely] (A) timely access to a consultation team that includes a child psychiatrist, social worker and a care coordinator [: (2)] (B) patient care coordination and transitional services for behavioral health care [: and (3)] (C) training and education concerning patient access to behavioral health services. [Said] Such program may provide to the pediatric patient of a primary care provider who serves children up to three follow-up telehealth appointments with a mental health care provider after the primary care provider has utilized the program on behalf of such patient. The commissioner may enter into a contract for services to administer such program.

[(b) Not later than October 1, 2013, said commissioner shall submit a plan, in accordance with the provisions of section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to public health, children, human services and appropriations concerning the program to be established pursuant to subsection (a) of this section.]
[c] [b] The Commissioner of Children and Families may adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section.

Sec. 10. Section 1 of public act 21-9, as amended by section 3 of public act 21-133, is repealed and the following is substituted in lieu thereof

(Effective from passage):

(a) As used in this section:

(1) "Asynchronous" has the same meaning as provided in section 19a-906 of the general statutes.

(2) "Connecticut medical assistance program" means the state's Medicaid program and the Children's Health Insurance program administered by the Department of Social Services.

(3) "Facility fee" has the same meaning as provided in section 19a-508c of the general statutes.

(4) "Health record" has the same meaning as provided in section 19a-906 of the general statutes.

(5) "Medical history" has the same meaning as provided in section 19a-906 of the general statutes.

(6) "Medication-assisted treatment" has the same meaning as provided in section 19a-906 of the general statutes.

(7) "Originating site" has the same meaning as provided in section 19a-906 of the general statutes.

(8) "Peripheral devices" has the same meaning as provided in section 19a-906 of the general statutes.

(9) "Remote patient monitoring" has the same meaning as provided in section 19a-906 of the general statutes.

(10) "Store and forward transfer" has the same meaning as provided
in section 19a-906 of the general statutes.

(11) "Synchronous" has the same meaning as provided in section 19a-906 of the general statutes.

(12) "Telehealth" means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical, oral and mental health, and includes interaction between the patient at the originating site and the telehealth provider at a distant site, synchronous interactions, asynchronous store and forward transfers or remote patient monitoring, but does not include interaction through (A) facsimile, texting or electronic mail, or (B) audio-only telephone unless the telehealth provider is (i) in-network, or (ii) a provider enrolled in the Connecticut medical assistance program providing such health care or other health services to a Connecticut medical assistance program recipient.

(13) "Telehealth provider" means any person who is (A) an in-network provider or a provider enrolled in the Connecticut medical assistance program providing health care or other health services to a Connecticut medical assistance program recipient through the use of telehealth within such person's scope of practice and in accordance with the standard of care applicable to such person's profession, and (B) (i) a physician or physician assistant licensed under chapter 370 of the general statutes, physical therapist or physical therapist assistant licensed under chapter 376 of the general statutes, chiropractor licensed under chapter 372 of the general statutes, naturopath licensed under chapter 373 of the general statutes, podiatrist licensed under chapter 375 of the general statutes, occupational therapist or occupational therapy assistant licensed under chapter 372 of the general statutes, optometrist licensed under chapter 380 of the general statutes, registered nurse or advanced practice registered nurse licensed under chapter 383 of the general statutes, psychologist licensed under chapter 383 of the general statutes, marital and family therapist licensed under chapter 383a of the
general statutes, clinical social worker or master social worker licensed
under chapter 383b of the general statutes, alcohol and drug counselor
licensed under chapter 376b of the general statutes, professional
counselor licensed under chapter 383c of the general statutes, dietitian-
nutritionist certified under chapter 384b of the general statutes, speech
and language pathologist licensed under chapter 399 of the general
statutes, respiratory care practitioner licensed under chapter 381a of the
general statutes, audiologist licensed under chapter 397a of the general
statutes, pharmacist licensed under chapter 400j of the general statutes,
paramedic licensed pursuant to chapter 384d of the general statutes,
nurse-midwife licensed under chapter 377 of the general statutes,
dentist licensed under chapter 379 of the general statutes, behavior
analyst licensed under chapter 382a of the general statutes, genetic
counselor licensed under chapter 383d of the general statutes, music
therapist certified in the manner described in chapter 383f of the general
statutes, art therapist [certified] licensed in the manner described in
chapter 383g of the general statutes or athletic trainer licensed under
chapter 375a of the general statutes, or (ii) an appropriately licensed,
certified or registered physician, physician assistant, physical therapist,
physical therapist assistant, chiropractor, naturopath, podiatrist,
occupational therapist, occupational therapy assistant, optometrist,
registered nurse, advanced practice registered nurse, psychologist,
marital and family therapist, clinical social worker, master social
worker, alcohol and drug counselor, professional counselor, dietitian-
nutritionist, speech and language pathologist, respiratory care
practitioner, audiologist, pharmacist, paramedic, nurse-midwife,
dentist, behavior analyst, genetic counselor, music therapist, art
therapist or athletic trainer, in another state or territory of the United
States or the District of Columbia, that provides telehealth services
pursuant to his or her authority under any relevant order issued by the
Commissioner of Public Health and maintains professional liability
insurance or other indemnity against liability for professional
malpractice in an amount that is equal to or greater than that required
for similarly licensed, certified or registered Connecticut health care
providers.
(b) (1) Notwithstanding the provisions of section 19a-906 of the general statutes, during the period beginning on [the effective date of this section] May 20, 2021, and ending on June 30, 2023, a telehealth provider may only provide a telehealth service to a patient when the telehealth provider:

(A) Is communicating through real-time, interactive, two-way communication technology or store and forward transfer technology;

(B) Has determined whether the patient has health coverage that is fully insured, not fully insured or provided through Medicaid or the Children's Health Insurance Program [Medicaid or the Children's Health Insurance Program] the Connecticut medical assistance program, and whether the patient's health coverage, if any, provides coverage for the telehealth service;

(C) Has access to, or knowledge of, the patient's medical history, as provided by the patient, and the patient's health record, including the name and address of the patient's primary care provider, if any;

(D) Conforms to the standard of care applicable to the telehealth provider's profession and expected for in-person care as appropriate to the patient's age and presenting condition, except when the standard of care requires the use of diagnostic testing and performance of a physical examination, such testing or examination may be carried out through the use of peripheral devices appropriate to the patient's condition; and

(E) Provides the patient with the telehealth provider's license number, if any, and contact information.

(2) Notwithstanding the provisions of section 19a-906 of the general statutes, if a telehealth provider provides a telehealth service to a patient during the period beginning on [the effective date of this section] May 10, 2021, and ending on June 30, 2023, the telehealth provider shall, at the time of the telehealth provider's first telehealth interaction with a patient, inform the patient concerning the treatment methods and limitations of treatment using a telehealth platform, including, but not limited to, the limited duration of the relevant provisions of this section.
and sections 3 to 7, inclusive, of [this act] public act 21-9, and, after providing the patient with such information, obtain the patient's consent to provide telehealth services. The telehealth provider shall document such notice and consent in the patient's health record. If a patient later revokes such consent, the telehealth provider shall document the revocation in the patient's health record.

(c) Notwithstanding the provisions of this section or title 20 of the general statutes, no telehealth provider shall, during the period beginning on [the effective date of this section] May 10, 2021, and ending on June 30, 2024, prescribe any schedule I, II or III controlled substance through the use of telehealth, except a schedule II or III controlled substance other than an opioid drug, as defined in section 20-14o of the general statutes, in a manner fully consistent with the Ryan Haight Online Pharmacy Consumer Protection Act, 21 USC 829(e), as amended from time to time, for the treatment of a person with a psychiatric disability or substance use disorder, as defined in section 17a-458 of the general statutes, including, but not limited to, medication-assisted treatment. A telehealth provider using telehealth to prescribe a schedule II or III controlled substance pursuant to this subsection shall electronically submit the prescription pursuant to section 21a-249 of the general statutes, as amended by this act.

(d) During the period beginning on [the effective date of this section] May 10, 2021, and ending on June 30, 2024, each telehealth provider shall, at the time of the initial telehealth interaction, ask the patient whether the patient consents to the telehealth provider's disclosure of records concerning the telehealth interaction to the patient's primary care provider. If the patient consents to such disclosure, the telehealth provider shall provide records of all telehealth interactions during such period to the patient's primary care provider, in a timely manner, in accordance with the provisions of sections 20-7b to 20-7e, inclusive, of the general statutes.

(e) During the period beginning on [the effective date of this section] May 10, 2021, and ending on June 30, 2024, any consent or
revocation of consent under this section shall be obtained from or
communicated by the patient, or the patient's legal guardian,
conservator or other authorized representative, as applicable.

(f) (1) The provision of telehealth services and health records
maintained and disclosed as part of a telehealth interaction shall comply
with all provisions of the Health Insurance Portability and
Accountability Act of 1996 P.L. 104-191, as amended from time to time,
and the rules and regulations adopted thereunder, that are applicable to
such provision, maintenance or disclosure.

(2) Notwithstanding the provisions of section 19a-906 of the general
statutes and subdivision (1) of this subsection, a telehealth provider that
is an in-network provider or a provider enrolled in the Connecticut
medical assistance program that provides telehealth services to a
Connecticut medical assistance program recipient, may, during the
period beginning on [the effective date of this section] May 10, 2021, and
ending on June 30, [2023] 2024, use any information or communication
technology in accordance with the directions, modifications or
revisions, if any, made by the Office for Civil Rights of the United States
Department of Health and Human Services to the provisions of the
Health Insurance Portability and Accountability Act of 1996 P.L. 104-
191, as amended from time to time, or the rules and regulations adopted
thereunder.

(g) Notwithstanding any provision of the general statutes, nothing in
this section shall, during the period beginning on [the effective date of
this section] May 10, 2021, and ending on June 30, [2023] 2024, prohibit
a health care provider from: (1) Providing on-call coverage pursuant to
an agreement with another health care provider or such health care
provider's professional entity or employer; (2) consulting with another
health care provider concerning a patient's care; (3) ordering care for
hospital outpatients or inpatients; or (4) using telehealth for a hospital
inpatient, including for the purpose of ordering medication or treatment
for such patient in accordance with the Ryan Haight Online Pharmacy
Consumer Protection Act, 21 USC 829(e), as amended from time to time.
As used in this subsection, "health care provider" means a person or entity licensed or certified pursuant to chapter 370, 372, 373, 375, 376 to 376b, inclusive, 378, 379, 380, 381a, 383 to 383c, inclusive, 384b, 397a, 399 or 400j of the general statutes or licensed or certified pursuant to chapter 368d or 384d of the general statutes.

(h) Notwithstanding any provision of the general statutes, no telehealth provider shall charge a facility fee for a telehealth service provided during the period beginning on [the effective date of this section] May 10, 2021, and ending on June 30, [2023] 2024.

(i) (1) Notwithstanding any provision of the general statutes, no telehealth provider shall provide health care or health services to a patient through telehealth during the period beginning on [the effective date of this section] May 10, 2021, and ending on June 30, [2023] 2024, unless the telehealth provider has determined whether or not the patient has health coverage for such health care or health services.

(2) Notwithstanding any provision of the general statutes, a telehealth provider who provides health care or health services to a patient through telehealth during the period beginning on [the effective date of this section] May 10, 2021, and ending on June 30, [2023] 2024, shall:

(A) Accept as full payment for such health care or health services:

(i) An amount that is equal to the amount that Medicare reimburses for such health care or health services if the telehealth provider determines that the patient does not have health coverage for such health care or health services; or

(ii) The amount that the patient's health coverage reimburses, and any coinsurance, copayment, deductible or other out-of-pocket expense imposed by the patient's health coverage, for such health care or health services if the telehealth provider determines that the patient has health coverage for such health care or health services.

(3) If a telehealth provider determines that a patient is unable to pay
for any health care or health services described in subdivisions (1) and (2) of this subsection, the provider shall offer to the patient financial assistance, if such provider is otherwise required to offer to the patient such financial assistance, under any applicable state or federal law.

(j) Subject to compliance with all applicable federal requirements, notwithstanding any provision of the general statutes, state licensing standards or any regulation adopted thereunder, a telehealth provider may provide telehealth services pursuant to the provisions of this section from any location.

(k) Notwithstanding the provisions of section 19a-906 of the general statutes, during the period beginning on [the effective date of this section] May 10, 2021, and ending on June 30, [2023] 2024, any Connecticut entity, institution or health care provider that engages or contracts with a telehealth provider that is licensed, certified or registered in another state or territory of the United States or the District of Columbia to provide health care or other health services shall verify the credentials of such provider in the state in which he or she is licensed, certified or registered, ensure that such a provider is in good standing in such state, and confirm that such provider maintains professional liability insurance or other indemnity against liability for professional malpractice in an amount that is equal to or greater than that required for similarly licensed, certified or registered Connecticut health care providers.

(l) Notwithstanding sections 4-168 to 4-174, inclusive, of the general statutes, from the period beginning on [the effective date of this section] May 10, 2021, and ending on June 30, [2023] 2024, the Commissioner of Public Health may temporarily waive, modify or suspend any regulatory requirements adopted by the Commissioner of Public Health or any boards or commissions under chapters 368a, 368d, 368v, 369 to 381a, inclusive, 382a, 383 to 388, inclusive, 397a, 398, 399, 400a, 400c, 400j and 474 of the general statutes as the Commissioner of Public Health deems necessary to reduce the spread of COVID-19 and to protect the public health for the purpose of providing residents of this state with
telehealth services from out-of-state practitioners.

Sec. 11. Subsection (c) of section 21a-249 of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage):

(c) A licensed practitioner shall not be required to electronically transmit a prescription when:

(1) Electronic transmission is not available due to a temporary technological or electrical failure. In the event of a temporary technological or electrical failure, the practitioner shall, without undue delay, reasonably attempt to correct any cause for the failure that is within his or her control. A practitioner who issues a prescription, but fails to electronically transmit the prescription, as permitted by this subsection, shall document the reason for the practitioner's failure to electronically transmit the prescription in the patient's medical record as soon as practicable, but in no instance more than seventy-two hours following the end of the temporary technological or electrical failure that prevented the electronic transmittal of the prescription. For purposes of this subdivision, "temporary technological or electrical failure" means failure of a computer system, application or device or the loss of electrical power to such system, application or device, or any other service interruption to such system, application or device that reasonably prevents the practitioner from utilizing his or her certified application to electronically transmit the prescription in accordance with subsection (b) of this section;

(2) The practitioner reasonably determines that it would be impractical for the patient to obtain substances prescribed by an electronically transmitted prescription in a timely manner and that such delay would adversely impact the patient's medical condition, provided if such prescription is for a controlled substance, the quantity of such controlled substance does not exceed a five-day supply for the patient, if the controlled substance was used in accordance with the directions for use. A practitioner who issues a prescription, but fails to electronically transmit the prescription, as permitted by this subsection,
shall document the reason for the practitioner's failure to electronically transmit the prescription in the patient's medical record;

(3) The prescription is to be dispensed by a pharmacy located outside this state. A practitioner who issues a prescription, but fails to electronically transmit the prescription, as permitted by this subsection, shall document the reason for the practitioner's failure to electronically transmit the prescription in the patient's medical record;

(4) Use of an electronically transmitted prescription may negatively impact patient care, such as a prescription containing two or more products to be compounded by a pharmacist, a prescription for direct administration to a patient by parenteral, intravenous, intramuscular, subcutaneous or intraspinal infusion, a prescription that contains long or complicated directions, a prescription that requires certain elements to be included by the federal Food and Drug and Administration, or an oral prescription communicated to a pharmacist by a health care practitioner for a patient in a chronic and convalescent nursing home, licensed pursuant to chapter 368v; or

(5) The practitioner demonstrates, in a form and manner prescribed by the commissioner, that such practitioner does not have the technological capacity to issue electronically transmitted prescriptions. For the purposes of this subsection, "technological capacity" means possession of a computer system, hardware or device that can be used to electronically transmit controlled substance prescriptions consistent with the requirements of the federal Controlled Substances Act, 21 USC 801, as amended from time to time. The provisions of this subdivision shall not apply to a practitioner when such practitioner is prescribing as a telehealth provider, as defined in section 19a-906, section 1 of public act 20-2 of the July special session or section 1 of public act 21-9, as amended by this act, as applicable, pursuant to subsection (c) of section 19a-906, subsection (c) of section 1 of public act 20-2 of the July special session or subsection (c) of section 1 of public act 21-9, as amended by this act, as applicable.

Sec. 12. Section 3 of public act 21-9 is repealed and the following is
substituted in lieu thereof (Effective from passage):

(a) For the purposes of this section:

(1) "Asynchronous" has the same meaning as provided in section 19a-906 of the general statutes;

(2) "Originating site" has the same meaning as provided in section 19a-906 of the general statutes;

(3) "Remote patient monitoring" has the same meaning as provided in section 19a-906 of the general statutes;

(4) "Store and forward transfer" has the same meaning as provided in section 19a-906 of the general statutes;

(5) "Synchronous" has the same meaning as provided in section 19a-906 of the general statutes;

(6) "Telehealth" means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of an insured's physical, oral and mental health, and includes interaction between the insured at the originating site and the telehealth provider at a distant site, synchronous interactions, asynchronous store and forward transfers or remote patient monitoring, but does not include interaction through (A) facsimile, texting or electronic mail, or (B) audio-only telephone if the telehealth provider is out-of-network; and

(7) "Telehealth provider" means any person who (A) provides health care or other health services through the use of telehealth within such person's scope of practice and in accordance with the standard of care applicable to such person's profession, and (B) is (i) a physician or physician assistant licensed under chapter 370 of the general statutes, physical therapist or physical therapist assistant licensed under chapter 376 of the general statutes, chiropractor licensed under chapter 372 of the general statutes, naturopath licensed under chapter 373 of the general statutes, etc.
Podiatrist licensed under chapter 375 of the general statutes, occupational therapist or occupational therapy assistant licensed under chapter 376a of the general statutes, optometrist licensed under chapter 380 of the general statutes, registered nurse or advanced practice registered nurse licensed under chapter 378 of the general statutes, psychologist licensed under chapter 383 of the general statutes, marital and family therapist licensed under chapter 383a of the general statutes, clinical social worker or master social worker licensed under chapter 383b of the general statutes, alcohol and drug counselor licensed under chapter 376b of the general statutes, professional counselor licensed under chapter 383c of the general statutes, dietitian-nutritionist certified under chapter 384b of the general statutes, speech and language pathologist licensed under chapter 399 of the general statutes, respiratory care practitioner licensed under chapter 381a of the general statutes, audiologist licensed under chapter 397a of the general statutes, pharmacist licensed under chapter 400j of the general statutes, paramedic licensed pursuant to chapter 384d of the general statutes, nurse-midwife licensed under chapter 377 of the general statutes, dentist licensed under chapter 379 of the general statutes, behavior analyst licensed under chapter 382a of the general statutes, genetic counselor licensed under chapter 383d of the general statutes, music therapist certified in the manner described in chapter 383f of the general statutes, art therapist [licensed] in the manner described in chapter 383g of the general statutes or athletic trainer licensed under chapter 375a of the general statutes, or (ii) an in-network and appropriately licensed, certified or registered physician, physician assistant, physical therapist, physical therapist assistant, chiropractor, naturopath, podiatrist, occupational therapist, occupational therapy assistant, optometrist, registered nurse, advanced practice registered nurse, psychologist, marital and family therapist, clinical social worker, master social worker, alcohol and drug counselor, professional counselor, dietitian-nutritionist, speech and language pathologist, respiratory care practitioner, audiologist, pharmacist, paramedic, nurse-midwife, dentist, behavior analyst, genetic counselor, music therapist, art therapist or athletic trainer, in another state or territory of the United States.
States or the District of Columbia, that provides telehealth services pursuant to his or her authority under any relevant order issued by the Commissioner of Public Health and maintains professional liability insurance or other indemnity against liability for professional malpractice in an amount that is equal to or greater than that required for similarly licensed, certified or registered Connecticut health care providers.

(b) Notwithstanding any provision of the general statutes, each individual health insurance policy that provides coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes that is effective at any time during the period beginning on [the effective date of this section] May 10, 2021, and ending on June 30, [2023] 2024, shall, at all times that the policy remains in effect during such period, provide coverage for medical advice, diagnosis, care or treatment provided through telehealth, to the same extent coverage is provided for such advice, diagnosis, care or treatment when provided to the insured in person. The policy shall not, at any time during such period, exclude coverage for a service that is appropriately provided through telehealth because such service is provided through telehealth or a telehealth platform selected by an in-network telehealth provider.

(c) Notwithstanding any provision of the general statutes, no telehealth provider who receives a reimbursement for a covered service provided through telehealth in accordance with subsection (b) of this section shall seek any payment for such service from the insured who received such service, except for any coinsurance, copayment, deductible or other out-of-pocket expense set forth in the insured’s policy. Such amount shall be deemed by the telehealth provider to be payment in full.

(d) Nothing in this section shall prohibit or limit a health insurer, health care center, hospital service corporation, medical service corporation or other entity from conducting utilization review for telehealth services, provided such utilization review is conducted in the
same manner and uses the same clinical review criteria as a utilization
review for an in-person consultation for the same service. Except as
provided in subsection (b) or (c) of this section, the coverage required
under subsection (b) of this section shall be subject to the same terms
and conditions applicable to all other benefits under the policy
providing such coverage.

Sec. 13. Section 4 of public act 21-9 is repealed and the following is
substituted in lieu thereof (Effective from passage):

(a) For the purposes of this section:

(1) "Asynchronous" has the same meaning as provided in section 19a-906 of the general statutes;

(2) "Originating site" has the same meaning as provided in section 19a-906 of the general statutes;

(3) "Remote patient monitoring" has the same meaning as provided in section 19a-906 of the general statutes;

(4) "Store and forward transfer" has the same meaning as provided in section 19a-906 of the general statutes;

(5) "Synchronous" has the same meaning as provided in section 19a-906 of the general statutes;

(6) "Telehealth" means the mode of delivering health care or other
health services via information and communication technologies to
facilitate the diagnosis, consultation and treatment, education, care
management and self-management of an insured's physical, oral and
mental health, and includes interaction between the insured at the
originating site and the telehealth provider at a distant site, synchronous
interactions, asynchronous store and forward transfers or remote
patient monitoring, but does not include interaction through (A)
facsimile, texting or electronic mail, or (B) audio-only telephone if the
telehealth provider is out-of-network; and
(7) "Telehealth provider" means any person who (A) provides health care or other health services through the use of telehealth within such person's scope of practice and in accordance with the standard of care applicable to such person's profession, and (B) is (i) a physician or physician assistant licensed under chapter 370 of the general statutes, physical therapist or physical therapist assistant licensed under chapter 376 of the general statutes, chiropractor licensed under chapter 372 of the general statutes, naturopath licensed under chapter 373 of the general statutes, podiatrist licensed under chapter 375 of the general statutes, occupational therapist or occupational therapy assistant licensed under chapter 376a of the general statutes, optometrist licensed under chapter 380 of the general statutes, registered nurse or advanced practice registered nurse licensed under chapter 378 of the general statutes, psychologist licensed under chapter 383 of the general statutes, marital and family therapist licensed under chapter 383a of the general statutes, clinical social worker or master social worker licensed under chapter 383b of the general statutes, alcohol and drug counselor licensed under chapter 376b of the general statutes, professional counselor licensed under chapter 383c of the general statutes, dietitian-nutritionist certified under chapter 384b of the general statutes, speech and language pathologist licensed under chapter 399 of the general statutes, respiratory care practitioner licensed under chapter 381a of the general statutes, audiologist licensed under chapter 397a of the general statutes, pharmacist licensed under chapter 400j of the general statutes, paramedic licensed pursuant to chapter 384d of the general statutes, nurse-midwife licensed under chapter 377 of the general statutes, dentist licensed under chapter 379 of the general statutes, behavior analyst licensed under chapter 382a of the general statutes, genetic counselor licensed under chapter 383d of the general statutes, music therapist certified in the manner described in chapter 383f of the general statutes, art therapist [certified] licensed in the manner described in chapter 383g of the general statutes or athletic trainer licensed under chapter 375a of the general statutes, or (ii) an in-network and appropriately licensed, certified or registered physician, physician assistant, physical therapist, physical therapist assistant, chiropractor,
naturopath, podiatrist, occupational therapist, occupational therapy assistant, optometrist, registered nurse, advanced practice registered nurse, psychologist, marital and family therapist, clinical social worker, master social worker, alcohol and drug counselor, professional counselor, dietitian-nutritionist, speech and language pathologist, respiratory care practitioner, audiologist, pharmacist, paramedic, nurse-midwife, dentist, behavior analyst, genetic counselor, music therapist, art therapist or athletic trainer, in another state or territory of the United States or the District of Columbia, that provides telehealth services pursuant to his or her authority under any relevant order issued by the Commissioner of Public Health and maintains professional liability insurance or other indemnity against liability for professional malpractice in an amount that is equal to or greater than that required for similarly licensed, certified or registered Connecticut health care providers.

(b) Notwithstanding any provision of the general statutes, each group health insurance policy that provides coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes that is effective at any time during the period beginning on [the effective date of this section] May 10, 2021[, and ending on June 30, 2023], shall, at all times that the policy remains in effect during such period, provide coverage for medical advice, diagnosis, care or treatment provided through telehealth, to the same extent coverage is provided for such advice, diagnosis, care or treatment when provided to the insured in person. The policy shall not, at any time during such period, exclude coverage for a service that is appropriately provided through telehealth because such service is provided through telehealth or a telehealth platform selected by an in-network telehealth provider.

(c) Notwithstanding any provision of the general statutes, no telehealth provider who receives a reimbursement for a covered service provided through telehealth in accordance with subsection (b) of this section shall seek any payment for such service from the insured who received such service, except for any coinsurance, copayment,
deductible or other out-of-pocket expense set forth in the insured's policy. Such amount shall be deemed by the telehealth provider to be payment in full.

(d) Nothing in this section shall prohibit or limit a health insurer, health care center, hospital service corporation, medical service corporation or other entity from conducting utilization review for telehealth services, provided such utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for an in-person consultation for the same service. Except as provided in subsection (b) or (c) of this section, the coverage required under subsection (b) of this section shall be subject to the same terms and conditions applicable to all other benefits under the policy providing such coverage.

Sec. 14. Section 5 of public act 21-9 is repealed the following is substituted in lieu thereof (Effective from passage):

(a) As used in this section:

(1) "Health carrier" has the same meaning as provided in section 38a-1080 of the general statutes;

(2) "Insured" has the same meaning as provided in section 38a-1 of the general statutes;

(3) "Telehealth" has the same meaning as provided in sections 3 and 4 of public act 21-9, as amended by this act; and

(4) "Telehealth provider" has the same meaning as provided in sections 3 and 4 of public act 21-9, as amended by this act.

(b) Notwithstanding any provision of the general statutes, no health carrier shall reduce the amount of a reimbursement paid to a telehealth provider for covered health care or health services that the telehealth provider appropriately provided to an insured through telehealth during the period beginning on [the effective date of this section] May 10, 2021, and ending on June 30, 2024, because the telehealth

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provider provided such health care or health services to the patient through telehealth and not in person.

Sec. 15. Section 7 of public act 21-9 is repealed and the following is substituted in lieu thereof (Effective from passage):

(a) As used in this section:

(1) "Advanced practice registered nurse" means an advanced practice registered nurse licensed pursuant to chapter 378 of the general statutes;

(2) "Physician" has the same meaning as provided in section 21a-408 of the general statutes;

(3) "Qualifying patient" has the same meaning as provided in section 21a-408 of the general statutes; and

(4) "Written certification" has the same meaning as provided in section 21a-408 of the general statutes.

(b) Notwithstanding the provisions of sections 21a-408 to 21a-408n, inclusive, of the general statutes, or any other section, regulation, rule, policy or procedure concerning the certification of medical marijuana patients, a physician or advanced practice registered nurse may issue a written certification to a qualifying patient and provide any follow-up care using telehealth services during the period beginning on [the effective date of this section] May 10, 2021, and ending on June 30, [2023] 2024, provided all other requirements for issuing the written certification to the qualifying patient and all recordkeeping requirements are satisfied.

Sec. 16. Section 38a-1041 of the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2022):

(a) There is established an Office of the Healthcare Advocate which shall be within the Insurance Department for administrative purposes only.

(b) The Office of the Healthcare Advocate may:
(1) Assist health insurance consumers with managed care plan selection by providing information, referral and assistance to individuals about means of obtaining health insurance coverage and services;

(2) Assist health insurance consumers to understand their rights and responsibilities under managed care plans;

(3) Provide information to the public, agencies, legislators and others regarding problems and concerns of health insurance consumers and make recommendations for resolving those problems and concerns;

(4) Assist consumers with the filing of complaints and appeals, including filing appeals with a managed care organization's internal appeal or grievance process and the external appeal process established under sections 38a-591d to 38a-591g, inclusive;

(5) Analyze and monitor the development and implementation of federal, state and local laws, regulations and policies relating to health insurance consumers and recommend changes it deems necessary;

(6) Facilitate public comment on laws, regulations and policies, including policies and actions of health insurers;

(7) Ensure that health insurance consumers have timely access to the services provided by the office;

(8) Review the health insurance records of a consumer who has provided written consent for such review;

(9) Create and make available to employers a notice, suitable for posting in the workplace, concerning the services that the Healthcare Advocate provides;

(10) Establish a toll-free number, or any other free calling option, to allow customer access to the services provided by the Healthcare Advocate;

(11) Pursue administrative remedies on behalf of and with the
consent of any health insurance consumers;

(12) Adopt regulations, pursuant to chapter 54, to carry out the provisions of sections 38a-1040 to 38a-1050, inclusive; and

(13) Take any other actions necessary to fulfill the purposes of sections 38a-1040 to 38a-1050, inclusive.

c) The Office of the Healthcare Advocate shall make a referral to the Insurance Commissioner if the Healthcare Advocate finds that a preferred provider network may have engaged in a pattern or practice that may be in violation of sections 38a-479aa to 38a-479gg, inclusive, or 38a-815 to 38a-819, inclusive.

d) The Healthcare Advocate and the Insurance Commissioner shall jointly compile a list of complaints received against managed care organizations and preferred provider networks and the commissioner shall maintain the list, except the names of complainants shall not be disclosed if such disclosure would violate the provisions of section 4-61dd or 38a-1045.

e) On or before October 1, 2005, the Managed Care Ombudsman shall establish a process to provide ongoing communication among mental health care providers, patients, state-wide and regional business organizations, managed care companies and other health insurers to assure: (1) Best practices in mental health treatment and recovery; (2) compliance with the provisions of sections 38a-476a, 38a-476b, 38a-488a, as amended by this act, and 38a-489; and (3) the relative costs and benefits of providing effective mental health care coverage to employees and their families. On or before January 1, 2006, and annually thereafter, the Healthcare Advocate shall report, in accordance with the provisions of section 11-4a, on the implementation of this subsection to the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance.

f) On or before October 1, 2008, the Office of the Healthcare
Advocate shall, within available appropriations, establish and maintain a healthcare consumer information web site on the Internet for use by the public in obtaining healthcare information, including but not limited to: (1) The availability of wellness programs in various regions of Connecticut, such as disease prevention and health promotion programs; (2) quality and experience data from hospitals licensed in this state; and (3) a link to the consumer report card developed and distributed by the Insurance Commissioner pursuant to section 38a-478l.

(g) [Not later than January 1, 2015, the] The Office of the Healthcare Advocate shall establish an information and referral service to help residents and providers receive behavioral health care information, timely referrals and access to behavioral health care providers. In developing and implementing such service, the Healthcare Advocate, or the Healthcare Advocate's designee, shall: (1) Collaborate with stakeholders, including, but not limited to, (A) state agencies, (B) the Behavioral Health Partnership established pursuant to section 17a-22h, (C) community collaboratives, (D) the United Way's 2-1-1 Infoline program, and (E) providers; (2) identify any basis that prevents residents from obtaining adequate and timely behavioral health care services, including, but not limited to, (A) gaps in private behavioral health care services and coverage, and (B) barriers to access to care; (3) coordinate a public awareness and educational campaign directing residents to the information and referral service; and (4) develop data reporting mechanisms to determine the effectiveness of the service, including, but not limited to, tracking (A) the number of referrals to providers by type and location of providers, (B) waiting time for services, and (C) the number of providers who accept or reject requests for service based on type of health care coverage. Not later than February 1, 2016, and annually thereafter, the Office of the Healthcare Advocate shall submit a report, in accordance with the provisions of section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to children, human services, public health and insurance. The report shall identify gaps in services and the resources needed to improve behavioral health care options for
residents.

(h) Not later than October 1, 2022, the Healthcare Advocate shall designate an employee of the Office of the Healthcare Advocate to be responsible for: (1) Performing the office's duties to minors; and (2) coordinating state-wide efforts to ensure that minors have coverage, and access to services, for behavioral health conditions, mental health conditions and substance use disorders.

Sec. 17. (NEW) (Effective from passage) (a) Not later than January 1, 2023, and annually thereafter, the Commissioner of Education shall, within available appropriations, develop and distribute a survey to each local and regional board of education concerning the employment of school social workers by such local or regional board of education. Such survey shall include, but need not be limited to, (1) the total number of school social workers employed by each local or regional board of education, (2) the number of school social workers assigned to each school under the jurisdiction of the local or regional board of education, including whether any such school social worker is assigned solely to that school or whether such school social worker is assigned to multiple schools, (3) the geographic area covered by any such school social worker who provides services to more than one local or regional board of education, and (4) an estimate of the annual number of students who have received direct services from each individual social worker employed by a local or regional board of education during the five-year period preceding completion of the survey.

(b) For the school year commencing July 1, 2022, and each school year thereafter, each local and regional board of education shall annually complete the survey developed and distributed pursuant to subsection (a) of this section to the commissioner, and submit such completed survey to the commissioner, at such time and in such manner as the commissioner prescribes.

(c) Following the receipt of a completed survey from a local or regional board of education, the commissioner shall annually calculate a student-to-school social worker ratio for (1) such board of education,
and (2) each school under the jurisdiction of such board of education.

(d) Not later than January 1, 2023, and annually thereafter, the commissioner shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, on the results of the survey completed under this section and the student-to-school social worker ratios calculated pursuant to subsection (c) of this section, to the joint standing committees of the General Assembly having cognizance of matters relating to education and children.

Sec. 18. (NEW) (Effective July 1, 2022) (a) For the fiscal years ending June 30, 2023, to June 30, 2025, inclusive, the Department of Education shall administer a grant program to provide grants to local and regional boards of education for the purpose of hiring and retaining additional student mental health specialists. As used in this section, "student mental health specialist" includes a school social worker, school psychologist, trauma specialist, behavior technician and board certified behavior analyst.

(b) Applications for grants pursuant to subsection (a) of this section shall be filed with the Commissioner of Education at such time and in such manner as the commissioner prescribes. As part of the application, an applicant shall submit a (1) plan for the expenditure of grant funds, and (2) copy of the completed survey described in section 17 of this act. Such plan shall include, but need not be limited to, the number of additional student mental health specialists to be hired, the number of student mental health specialists being retained who were previously hired with the assistance of grant funds awarded under this section, whether such student mental health specialists will be conducting assessments of students or providing services to students based on the results of assessments and the type of services that will be provided by such student mental health specialists.

(c) In determining whether to award an applicant a grant under this section, the commissioner shall give priority to those school districts (1) with large student-to-student mental health specialist ratios, or (2) that have a high volume of student utilization of mental health services.
(d) For the fiscal year ending June 30, 2023, the commissioner may
award a grant to an applicant and shall determine the amount of the
grant award based on the plan submitted by such applicant pursuant to
subsection (b) of this section. The commissioner shall pay a grant to each
grant recipient in each of the fiscal years ending June 30, 2023, to June
30, 2025, inclusive, as follows: (1) For the fiscal year ending June 30, 2023,
the amount of the grant shall be as determined by the commissioner
under this subsection; (2) for the fiscal year ending June 30, 2024, the
amount of the grant shall be the same amount as the grant awarded for
the prior fiscal year; and (3) for the fiscal year ending June 30, 2025, the
amount of the grant shall be seventy per cent of the amount of the grant
awarded for the prior fiscal year.

(e) Grant recipients shall file annual expenditure reports with the
department at such time and in such manner as the commissioner
prescribes. Grant recipients shall refund to the department (1) any
unexpended amounts at the close of the fiscal year in which the grant
was awarded, and (2) any amounts not expended in accordance with
the plan for which such grant application was approved.

(f) (1) The department shall annually track and calculate the
utilization rate of the grant program for each grant recipient. Such
utilization rate shall be calculated using metrics that include, but need
not be limited to, the number of students served and the hours of service
provided using grant funds awarded under the program.

(2) The department shall annually calculate the return on investment
for the grant program using the expenditure reports filed pursuant to
subsection (e) of this section and the utilization rates calculated
pursuant to subdivision (1) of this subsection.

(g) For purposes of carrying out the provisions of this section, the
Department of Education may accept funds from private sources or any
state agency, gifts, grants and donations, including, but not limited to,
in-kind donations.

(h) (1) Not later than January 1, 2024, and each January first thereafter
until and including January 1, 2026, the commissioner shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, on the utilization rate for each grant recipient and the return on investment for the grant program, calculated pursuant to subsection (f) of this section, to the joint standing committees of the General Assembly having cognizance of matters relating to education and children.

(2) Not later than January 1, 2026, the Commissioner of Education shall develop recommendations concerning (A) whether such grant program should be extended and funded for the fiscal year ending June 30, 2026, and each fiscal year thereafter, and (B) the amount of the grant award under the program. The commissioner shall submit such recommendations, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to education and children.

Sec. 19. (NEW) (Effective from passage) (a) For the fiscal years ending June 30, 2023, to June 30, 2025, inclusive, the Department of Education shall administer a grant program to provide grants to local and regional boards of education and public institutions of higher education, for the school-based delivery of mental health services to students.

(b) Applications for grants pursuant to subsection (a) of this section shall be filed with the Commissioner of Education at such time and in such manner as the commissioner prescribes. As part of the application, an applicant shall submit a plan for the expenditure of grant funds.

(c) For the fiscal year ending June 30, 2023, the commissioner may award a grant to an applicant and shall determine the amount of the grant award based on the plan submitted by such applicant pursuant to subsection (b) of this section. The commissioner shall pay a grant to each grant recipient in each of the fiscal years ending June 30, 2023, to June 30, 2025, inclusive, as follows: (1) For the fiscal year ending June 30, 2023, the amount of the grant shall be as determined by the commissioner under this subsection; (2) for the fiscal year ending June 30, 2024, the amount of the grant shall be the same amount as the grant awarded for
the prior fiscal year; and (3) for the fiscal year ending June 30, 2025, the
amount of the grant shall be seventy per cent of the amount of the grant
awarded for the prior fiscal year.

(d) Grant recipients shall file expenditure reports with the
Commissioner of Education at such time and in such manner as the
commissioner prescribes. Grant recipients shall refund to the
department (1) any unexpended amounts at the close of the fiscal year
in which the grant was awarded, and (2) any amounts not expended in
accordance with the plan for which such grant application was
approved.

(e) Each grant recipient, in collaboration with the department, shall
develop metrics to annually track and calculate the utilization rate of the
grant program for such grant recipient in order to measure the success
of the program. Such grant recipient shall annually submit such metrics
and utilization rate to the department.

(f) For the purposes of carrying out the provisions of this section, the
Department of Education may accept funds from private sources or any
other state agency, gifts, grants and donations, including, but not
limited to, in-kind contributions.

(g) (1) Not later than January 1, 2024, and each January first thereafter
until and including January 1, 2026, the commissioner shall submit a
report, in accordance with the provisions of section 11-4a of the general
statutes, on the utilization rate for each grant recipient calculated
pursuant to subsection (e) of this section, to the joint standing
committees of the General Assembly having cognizance of matters
relating to education and children.

(2) Not later than January 1, 2026, the Commissioner of Education
shall develop recommendations concerning (A) whether such grant
program should be extended and funded for the fiscal year ending June
30, 2026, and each fiscal year thereafter, and (B) the amount of the grant
award under the program. The commissioner shall submit such
recommendations, in accordance with the provisions of section 11-4a of
the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to education, higher education and children.

Sec. 20. (NEW) (Effective July 1, 2022) (a) The Department of Education, in collaboration with the Department of Social Services, shall annually provide information and resources to local and regional boards of education concerning the existence and availability of the 2-1-1 Infoline program, and other pediatric mental and behavioral health screening services and tools.

(b) Each local and regional board of education shall provide notice to the parent or guardian of a student who is truant, as defined in section 10-198a of the general statutes, as amended by this act, of the information provided by the Department of Education pursuant to subsection (a) of this section.

Sec. 21. Subsection (b) of section 10-198a of the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2022):

(b) Each local and regional board of education shall adopt and implement policies and procedures concerning truants who are enrolled in schools under the jurisdiction of such board of education. Such policies and procedures shall include, but need not be limited to, the following: (1) The holding of a meeting with the parent of each child who is a truant, or other person having control of such child, and appropriate school personnel to review and evaluate the reasons for the child being a truant, provided such meeting shall be held not later than ten school days after the child's fourth unexcused absence in a month or tenth unexcused absence in a school year, (2) coordinating services with and referrals of children to community agencies providing child and family services, (3) annually at the beginning of the school year and upon any enrollment during the school year, notifying the parent or other person having control of each child enrolled in a grade from kindergarten to eight, inclusive, in the public schools in writing of the obligations of the parent or such other person pursuant to section 10-
184, (4) annually at the beginning of the school year and upon any
enrollment during the school year, obtaining from the parent or other
person having control of each child in a grade from kindergarten to
eight, inclusive, a telephone number or other means of contacting such
parent or such other person during the school day, (5) (A) on or before
August 15, 2018, the implementation of a truancy intervention model
identified by the Department of Education pursuant to subsection (a) of
section 10-198e, as amended by this act, for any school under its
jurisdiction that has a disproportionately high rate of truancy, as
determined by the Commissioner of Education, and (B) on or before July
1, 2023, the adoption and implementation of a truancy intervention
model developed by the Department of Education pursuant to
subsection (b) of section 10-198e, as amended by this act, that accounts
for mental and behavioral health, (6) a system of monitoring individual
unexcused absences of children in grades kindergarten to eight,
inclusive, which shall provide that whenever a child enrolled in school
in any such grade fails to report to school on a regularly scheduled
school day and no indication has been received by school personnel that
the child’s parent or other person having control of the child is aware of
the pupil’s absence, a reasonable effort to notify, by telephone and by
mail, the parent or such other person shall be made by school personnel
or volunteers under the direction of school personnel, (7) providing
notice to the parent or guardian of a child who is a truant of the
information concerning the existence and availability of the 2-1-1
Infoline program, and other pediatric mental and behavioral health
screening services and tools provided by the Department of Education
pursuant to subsection (a) of section 20 of this act, (8) on and after July
1, 2023, a requirement that a school social worker or a school
psychologist conduct (A) an evaluation of each child who is a truant to
determine if additional behavioral health interventions are necessary for
the well-being of the child, and (B) a psychiatric evaluation of such child,
which shall include, to the extent possible, an evaluation of the
psychological, mental, emotional, economic and physical needs of the
child and the child’s family, and (9) a requirement that any school
resource officer be trained in the peer-to-peer mental health support
program described in section 41 of this act, so that they may be better
able to determine if additional mental health resources should be
utilized when dealing with students. Any person who, in good faith,
gives or fails to give notice pursuant to subdivision (6) of this subsection
shall be immune from any liability, civil or criminal, which might
otherwise be incurred or imposed and shall have the same immunity
with respect to any judicial proceeding which results from such notice
or failure to give such notice.

Sec. 22. Section 10-198e of the general statutes is repealed and the
following is substituted in lieu thereof (Effective July 1, 2022):

(a) The Department of Education shall identify effective truancy
intervention models for implementation by local and regional boards of
education pursuant to subsection (b) of section 10-198a, as amended by
this act, including intervention models that address the needs of
students with disabilities. Not later than August 15, 2018, a listing of
such approved models shall be available for implementation by local
and regional boards of education pursuant to said subsection (b).

(b) Not later than July 1, 2023, the Department of Education shall
develop and make available for implementation by local and regional
boards of education described in subparagraph (B) of subdivision (5) of
subsection (b) of section 10-198a, as amended by this act, a truancy
intervention model that accounts for mental and behavioral health.

(c) Not later than July 1, 2023, the Department of Education, in
collaboration with the Department of Children and Families, shall issue
guidance to local and regional boards of education on best practices
relating to intervention in certain behavioral health situations and when
it is appropriate to contact the 2-1-1 Infoline program or use alternative
interventions.

Sec. 23. Subsection (c) of section 17a-22bb of the 2022 supplement to
the general statutes is repealed and the following is substituted in lieu
thereof (Effective July 1, 2022):
(c) Local law enforcement agencies and local and regional boards of education that employ or engage school resource officers shall [provide federal funds are available.] train school resource officers in nationally recognized best practices and the peer-to-peer mental health support program, described in section 41 of this act, to prevent students with mental health issues from being victimized or disproportionately referred to the juvenile justice system as a result of their mental health issues.

Sec. 24. (NEW) (Effective July 1, 2022) There shall be a trauma coordinator within the Department of Education. The coordinator shall be responsible for: (1) Developing or procuring the system-wide, trauma-informed care training program described in section 25 of this act, (2) implementing the system-wide, trauma-informed care training program, (3) providing technical assistance to local and regional boards of education in the implementation of the system-wide, trauma-informed care training program, (4) training those persons who will be trainers under the system-wide, trauma-informed care training program, and (5) ensuring that the trainers are properly training teachers, administrators and other school staff and coaches and school resource officers under the system-wide, trauma-informed care training program.

Sec. 25. (NEW) (Effective July 1, 2022) The trauma coordinator, described in section 24 of this act, shall develop or procure a system-wide, trauma-informed care training program. Such training program shall utilize a train-the-trainer model to deliver trauma-informed care curriculum to all teachers, administrators and other school staff and coaches and school resource officers in the state. In developing or procuring such training program, the coordinator may collaborate with any nonprofit organization in the state that focuses on child health and development and trauma-informed care for children.

Sec. 26. (NEW) (Effective July 1, 2022) For the school year commencing July 1, 2022, and each school year thereafter, any teacher of record in a classroom may request the safe school climate specialist, as described in
section 10-222k of the general statutes, to convene a behavior intervention meeting for any student whose behavior has caused a serious disruption to the instruction of other students, or caused self-harm or physical harm to such teacher or another student or staff member in such teacher's classroom. The safe school climate specialist shall, upon the request of such teacher, convene a behavior intervention meeting regarding such student. The participants of such behavior intervention meeting shall identify resources and supports to address such student's social, emotional and instructional needs.

Sec. 27. Subsection (c) of section 10-220 of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2022):

(c) Annually, each local and regional board of education shall submit to the Commissioner of Education a strategic school profile report for each school and school or program of alternative education, as defined in section 10-74j, under its jurisdiction and for the school district as a whole. The superintendent of each local and regional school district shall present the profile report at the next regularly scheduled public meeting of the board of education after each November first. The profile report shall provide information on measures of (1) student needs, including, but not limited to, a needs assessment that identifies resources necessary to address the level of student trauma impacting students and staff in each school, (2) school resources, including technological resources and utilization of such resources and infrastructure, (3) student and school performance, including in-school suspensions, out-of-school suspensions and expulsions, the number of truants, as defined in section 10-198a, as amended by this act, and chronically absent children, as defined in section 10-198c, (4) the number of students enrolled in an adult high school credit diploma program, pursuant to section 10-69, operated by a local or regional board of education or a regional educational service center, (5) equitable allocation of resources among its schools, (6) reduction of racial, ethnic and economic isolation, (7) special education, and (8) school-based arrests, as defined in section 10-233n. For purposes of this subsection,
measures of special education include (A) special education identification rates by disability, (B) rates at which special education students are exempted from mastery testing pursuant to section 10-14q, (C) expenditures for special education, including such expenditures as a percentage of total expenditures, (D) achievement data for special education students, (E) rates at which students identified as requiring special education are no longer identified as requiring special education, (F) the availability of supplemental educational services for students lacking basic educational skills, (G) the amount of special education student instructional time with nondisabled peers, (H) the number of students placed out-of-district, and (I) the actions taken by the school district to improve special education programs, as indicated by analyses of the local data provided in subparagraphs (A) to (H), inclusive, of this subdivision. The superintendent shall include in the narrative portion of the report information about parental involvement and any measures the district has taken to improve parental involvement, including, but not limited to, employment of methods to engage parents in the planning and improvement of school programs and methods to increase support to parents working at home with their children on learning activities. For purposes of this subsection, measures of truancy include the type of data that is required to be collected by the Department of Education regarding attendance and unexcused absences in order for the department to comply with federal reporting requirements and the actions taken by the local or regional board of education to reduce truancy in the school district. Such truancy data shall be considered a public record, as defined in section 1-200.

Sec. 28. Subdivision (1) of subsection (a) of section 28-24 of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2022):

(1) Develop a state-wide emergency service telecommunications plan specifying emergency police, fire and medical service telecommunications systems needed to provide coordinated emergency service telecommunications to all state residents, including [the physically disabled] persons with physical disabilities and persons in
need of mental health, behavioral health or substance use disorder services;

Sec. 29. Subsection (c) of section 28-24 of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2022):

(c) Within a time period determined by the commissioner to ensure the availability of funds for the fiscal year beginning July 1, 1997, to the regional emergency telecommunications centers within the state, and not later than April first of each year thereafter, the commissioner shall determine the amount of funding needed for the development and administration of the enhanced emergency 9-1-1 program. The commissioner shall specify the expenses associated with (1) the purchase, installation and maintenance of new public safety answering point terminal equipment, (2) the implementation of the subsidy program, as described in subdivision (2) of subsection (a) of this section, (3) the establishment of incentives to encourage regionalization of public safety answering points, including the implementation of the transition grant program, described in subdivision (2) of subsection (a) of this section, (4) the implementation of the regional emergency telecommunications service credit, as described in subdivision (2) of subsection (a) of this section, provided, for the fiscal year ending June 30, 2001, and each fiscal year thereafter, such credit for coordinated medical emergency direction services as provided in regulations adopted under this section shall be based upon the factor of thirty cents per capita and shall not be reduced each year, (5) the training of personnel, as necessary, (6) recurring expenses and future capital costs associated with the telecommunications network used to provide emergency 9-1-1 service and the public safety services data networks, (7) for the fiscal year ending June 30, 2001, and each fiscal year thereafter, the collection, maintenance and reporting of emergency medical services data, as required under subparagraph (A) of subdivision (8) of section 19a-177, provided the amount of expenses specified under this subdivision shall not exceed two hundred fifty thousand dollars in any fiscal year, (8) for the fiscal year ending June 30,
2001, and each fiscal year thereafter, the initial training of emergency
medical dispatch personnel, the provision of an emergency medical
dispatch priority reference card set and emergency medical dispatch
training and continuing education pursuant to subdivisions (3) and (4)
of subsection [(g)] (h) of section 28-25b, (9) the administration of the
enhanced emergency 9-1-1 program by the Division of State-Wide
Emergency Telecommunications, as the commissioner determines to be
reasonably necessary, and (10) the implementation and maintenance of
the public safety data network established pursuant to section 29-1j. The
commissioner shall communicate the commissioner's findings to the
Public Utilities Regulatory Authority not later than April first of each
year.

Sec. 30. Section 28-25 of the general statutes is repealed and the
following is substituted in lieu thereof (Effective October 1, 2022):

As used in this section and sections 28-25a to 28-29b, inclusive:

(1) "Automatic number identification" means an enhanced 9-1-1
service and a next generation 9-1-1 telecommunication system
capability that enables the automatic display of the telephone number
used to place a 9-1-1 call.

(2) "Automatic location identification" means an enhanced 9-1-1
service and a next generation 9-1-1 telecommunication system
capability that enables the automatic display of information defining the
geographical location of the telephone used to place a 9-1-1 call.

(3) "Division" means the Division of State-Wide Emergency
Telecommunications.

(4) "Commission" means the E 9-1-1 Commission created by section
28-29a, as amended by this act.

(5) "Enhanced 9-1-1 service" means a service consisting of telephone
network features and public safety answering points provided for users
of the public telephone system enabling such users to reach a public
safety answering point by dialing the digits "9-1-1". Such service directs
9-1-1 calls to appropriate public safety answering points by selective routing based on the geographical location from which the call originated and provides the capability for automatic number identification and automatic location identification features.

(6) "Enhanced 9-1-1 network features" means those features of selective routing which have the capability of automatic number and location identification.

(7) "Municipality" means any town, city, borough, consolidated town and city or consolidated town and borough.

(8) "Public safety agency" means a functional division of a municipality or the state which provides fire fighting, law enforcement, ambulance, medical or other emergency services.

(9) "Private safety agency" means any entity, except a municipality or a public safety agency, providing emergency fire, ambulance or medical services.

(10) "Public safety answering point" means a facility, operated on a twenty-four-hour basis, assigned the responsibility of receiving 9-1-1 calls and, as appropriate, directly dispatching emergency response services, or transferring or relaying emergency 9-1-1 calls to other public safety agencies. A public safety answering point is the first point of reception by a public safety agency of a 9-1-1 call and serves the jurisdictions in which it is located or other participating jurisdictions.

(11) "Selective routing" means the method employed to direct 9-1-1 calls to the appropriate public safety answering point based on the geographical location from which the call originated.

(12) "Telephone company" includes every corporation, company, association, joint stock association, partnership or person, or lessee thereof, owning, leasing, maintaining, operating, managing or controlling poles, wires, conduits or other fixtures, in, under or over any public highway or street, for the provision of telephone exchange and other systems and methods of telecommunications and services related.
thereto in or between any or all of the municipalities of this state.

(13) "Private branch exchange" means an electronic telephone exchange installed on the user's premises to allow internal dialing from station to station within such premises and connection to outgoing and incoming lines to the public switched network of a telephone company.

(14) "Private safety answering point" means a facility within a private company, corporation or institution, operated on a twenty-four-hour basis, and assigned the responsibility of receiving 9-1-1 calls routed by a private branch exchange and, directly dispatching in-house emergency response services, or transferring or relaying emergency 9-1-1 calls to other public or private safety agencies.

(15) "Emergency medical dispatch" means the management of requests for emergency medical assistance by utilizing a system of (A) tiered response or priority dispatching of emergency medical resources based on the level of medical assistance needed by the victim, and (B) prearrival first aid or other medical instructions given by trained personnel who are responsible for receiving 9-1-1 calls and directly dispatching emergency response services.

(16) "Emergency notification system" means a service that notifies the public of an emergency.

(17) "Subscriber information" means the name, address and telephone number contained in the enhanced 9-1-1 service database of any telephone used to place a 9-1-1 call or that is used in connection with an emergency notification system.

(18) "Certified telecommunications provider" has the same meaning as provided in section 16-1.

(19) "Prepaid wireless telecommunications service" has the same meaning as provided in section 28-30b.

(20) "Next generation 9-1-1 telecommunication system" means a system comprised of managed Internet protocol networks that utilizes
enhanced 9-1-1 network features and enables users to reach a public
safety answering point by making a 9-1-1 call.

(21) "9-1-1 call" means a voice, text message, video or image
communication that is routed to a public safety answering point or a
private safety answering point by dialing or otherwise accessing the
digits "9-1-1".

(22) "Mental or behavioral health call" means a 9-1-1 call concerning
a person with mental health, behavioral health or substance use
disorder needs that may be routed without risk to public safety to an
entity specializing in the treatment of mental health, behavioral health
or substance use disorders, or an individual licensed pursuant to
chapter 383, 383a, 383b, 383c or 384d.

Sec. 31. Section 28-25b of the general statutes is repealed and the
following is substituted in lieu thereof (Effective October 1, 2022):

(a) Each public safety answering point shall be capable of
transmitting requests for law enforcement, fire fighting, medical,
ambulance or other emergency services to a public or private safety
agency that provides the requested services.

(b) Each public safety answering point shall be equipped with a
system approved by the division for the processing of requests for
emergency services from the physically disabled.

(c) Each public safety answering point shall (1) have on staff licensed
providers of behavioral health, mental health and substance use
disorder services to (A) provide crisis counselling to 9-1-1 callers who
require immediate mental health, behavioral health or substance use
disorder services, (B) assess such callers with regard to any ongoing
need for mental health, behavioral health or substance use disorder
services, and (C) refer such callers to providers of mental health,
behavioral health or substance use disorder services, as necessary, or (2)
be able to transfer such callers to an outside agency that provides
behavioral health, mental health and substance use disorder services.
[c] (d) No person shall connect to a telephone company's network any automatic alarm or other automatic alerting device which causes the number "9-1-1" to be automatically dialed and provides a prerecorded message in order to directly access emergency services, except for a device approved by the division.

[(d)] (e) Except as provided in subsection [(e)] (f) of this section, no person, firm or corporation shall program any telephone or associated equipment with outgoing access to the public switched network of a telephone company so as to prevent a 9-1-1 call from being transmitted from such telephone to a public safety answering point.

[(e)] (f) A private company, corporation or institution which has full-time law enforcement, fire fighting and emergency medical service personnel, with the approval of the division and the municipality in which it is located, may establish 9-1-1 service to enable users of telephones within their private branch exchange to reach a private safety answering point by dialing or otherwise accessing the digits "9-1-1". Such 9-1-1 service shall provide the capability to deliver and display automatic number identification and automatic location identification by electronic or manual methods approved by the division to the private safety answering point. Prior to the installation and utilization of such 9-1-1 service, each municipality in which it will function, shall submit a private branch exchange 9-1-1 utilization plan to the division in a format approved by the division. Such plan shall be approved by the chief executive officer of such municipality who shall attest that the dispatch of emergency response services from a private safety answering point is equal to, or better than, the emergency response services dispatched from a public safety answering point.

[(f)] (g) [On and after January 1, 2001, each] Each public safety answering point shall submit to the division, on a quarterly basis, a report of all 9-1-1 calls for services received through the enhanced 9-1-1 service and the next generation 9-1-1 telecommunication system by the public safety answering point. Such report shall include, but not be limited to, the following information: (1) The number of 9-1-1 calls
during the reporting quarter; and (2) the number of mental or behavioral health calls during the reporting quarter; and (3) for each such call, the elapsed time period from the time the call was received to the time the call was answered, and the elapsed time period from the time the call was answered to the time the call was transferred or terminated, expressed in time ranges or fractile response times. The information required under this subsection may be submitted in any written or electronic form selected by such public safety answering point and approved by the Commissioner of Emergency Services and Public Protection, provided the commissioner shall take into consideration the needs of such public safety answering point in approving such written or electronic form. On a quarterly basis, the division shall make such information available to the public and shall post such information on its Internet web site.

[(g)] (h) (1) [Not later than July 1, 2004, each] Each public safety answering point shall provide emergency medical dispatch, or shall arrange for emergency medical dispatch to be provided by a public safety agency, private safety agency or regional emergency telecommunications center, in connection with all 9-1-1 calls received by such public safety answering point for which emergency medical services are required. Any public safety answering point that arranges for emergency medical dispatch to be provided by a public safety agency, private safety agency or regional emergency telecommunications center shall file with the division such documentation as the division may require to demonstrate that such public safety agency, private safety agency or regional emergency telecommunications center satisfies the requirements of subdivisions (2) and (3) of this subsection.

(2) Each public safety answering point, public safety agency, private safety agency or regional emergency telecommunications center performing emergency medical dispatch in accordance with subdivision (1) of this subsection shall establish and maintain an emergency medical dispatch program. Such program shall include, but not be limited to, the following elements: (A) Medical interrogation,
dispatch prioritization and prearrival instructions in connection with 9-1-1 calls requiring emergency medical services shall be provided only by personnel who have been trained in emergency medical dispatch through satisfactory completion of a training course provided or approved by the division under subdivision (3) of this subsection; (B) a medically approved emergency medical dispatch priority reference system shall be utilized by such personnel; (C) emergency medical dispatch continuing education shall be provided for such personnel; (D) a mechanism shall be employed to detect and correct discrepancies between established emergency medical dispatch protocols and actual emergency medical dispatch practice; and (E) a quality assurance component shall be implemented to monitor, at a minimum, (i) emergency medical dispatch time intervals, (ii) the utilization of emergency medical dispatch program components, and (iii) the appropriateness of emergency medical dispatch instructions and dispatch protocols. The quality assurance component shall be prepared with the assistance of a physician licensed in this state who is trained in emergency medicine and shall provide for an ongoing review of the effectiveness of the emergency medical dispatch program.

(3) [Not later than July 1, 2001, the] The division shall provide an emergency medical dispatch training course and an emergency medical dispatch continuing education course, or approve any emergency medical dispatch training course and emergency medical dispatch continuing education course offered by other providers, that meets the requirements of the U.S. Department of Transportation, National Highway Traffic Safety Administration, Emergency Medical Dispatch (EMD): National Standard Curriculum, as from time to time amended.

(4) The division shall provide each public safety answering point or regional emergency telecommunications center performing emergency medical dispatch in accordance with subdivision (1) of this subsection with initial training of emergency medical dispatch personnel and an emergency medical dispatch priority reference card set.

(i) (1) Not later than January 1, 2023, the division shall establish
policies, procedures, and standards for mental or behavioral health calls, that shall include (A) staffing public safety answering points with licensed providers of behavioral health, mental health and substance use disorder services to (i) provide crisis counselling to 9-1-1 callers who require immediate mental health, behavioral health or substance use disorder services, (ii) assess such callers' needs with regard to any ongoing need for mental health, behavioral health or substance use disorder services, and (iii) refer such callers to providers of such services as necessary; (B) transferring mental or behavioral health calls to responders other than law enforcement, including, but not limited to, community organizations, mobile crisis teams, or local organizations or networks providing telephone support or referral services for persons with mental or behavioral health needs or with a substance use disorder; (C) requiring each public safety answering point to coordinate with the Department of Mental Health and Addiction Services on the implementation of mental health, behavioral health and substance use disorder protocols; (D) developing protocols for public safety answering points to transfer mental or behavioral health calls to the National Suicide Prevention Lifeline or 2-1-1, as appropriate; (E) establishing standards for training each telecommunicator, as defined in section 28-30, to respond to mental or behavioral health calls; (F) collecting data to evaluate the effectiveness of procedures used to transfer mental or behavioral health calls to the appropriate crisis hotline or services provider; and (G) establishing standards for initial and ongoing training of persons who respond to mental and behavioral health calls and the provision of division resources necessary to support such ongoing training.

(2) Not later than July 1, 2023, each public safety answering point shall incorporate the policies, procedures and standards for mental or behavioral health calls established by the division pursuant to subdivision (1) of this subsection.

(3) Any public safety answering point that arranges for mental health, behavioral health or substance use disorder services to be provided by a third party shall notify the division in a manner determined by the
division. The division shall maintain a record of third parties providing such services.

(4) The division shall provide each public safety answering point with initial and ongoing training of the policies, procedures and training standards for mental or behavioral health calls established by the division pursuant to subdivision (1) of this subsection.

Sec. 32. Section 28-29a of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2022):

(a) There is established an E 9-1-1 Commission to (1) advise the division in the planning, design, implementation and coordination of the state-wide emergency 9-1-1 telephone system [to be] created pursuant to sections 28-25 to 28-29b, inclusive, as amended by this act, and (2) in consultation with the Coordinating Advisory Board established pursuant to section 29-1t, as amended by this act, advise the Commissioner of Emergency Services and Public Protection in the planning, design, implementation, coordination and governance of the public safety data network established pursuant to section 29-1j.

(b) The commission shall be appointed by the Governor and shall consist of the following members: (1) One representative from the technical support services unit of the Division of State Police within the Department of Emergency Services and Public Protection; (2) the State Fire Administrator; (3) one representative from the Office of Emergency Medical Services; (4) one representative from the Division of Emergency Management and Homeland Security within the Department of Emergency Services and Public Protection; (5) the Commissioner of Public Health, or the commissioner's designee; (6) the Commissioner of Mental Health and Addiction Services, or the commissioner's designee; (7) the Commissioner of Children and Families, or the commissioner's designee; (8) one municipal police chief; [(6)] (9) one municipal fire chief; [(7)] (10) one volunteer fireman; [(8)] (11) one representative of the Connecticut Conference of Municipalities; [(9)] (12) one representative of the Council of Small Towns; [(10)] (13) one representative of telecommunicators, as defined in section 28-30; [(11)] (14) one
representative of the public; [(12)] (15) one manager or coordinator of 9-1-1 public safety answering points serving areas of differing population concentration; and [(13)] (16) one representative of providers of commercial mobile radio services, as defined in 47 Code of Federal Regulations 20.3, as amended. Each member shall serve for a term of three years from the date of his or her appointment or until a successor has been appointed and qualified. No member of the commission shall receive compensation for such member's services.

Sec. 33. Subsection (b) of section 29-1t of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2022):

(b) The Commissioner of Emergency Services and Public Protection, or said commissioner's designee, shall serve as the chairperson of the Coordinating Advisory Board. The board shall consist of: (1) The president of the Connecticut State Firefighters Association or a designee, representing volunteer firefighters; (2) the president of the Uniformed Professional Firefighters Association or a designee, representing professional firefighters; (3) the president of the American Federation of State, County and Municipal Employees, or a designee, representing municipal police officers; (4) the executive director of the Connecticut Conference of Municipalities or a designee; (5) the executive director of the Connecticut Council of Small Towns or a designee; (6) a member of the Police Officer Standards Training Council, designated by the chairperson of said council; (7) a member of the Commission on Fire Prevention and Control, designated by the chairperson of said commission; (8) the president of the Connecticut Emergency Management Association or a designee; (9) the president of the Connecticut Police Chiefs Association or a designee; (10) the president of the Connecticut Fire Chiefs Association or a designee; (11) the president of the Connecticut Career Fire Chiefs Association or a designee; (12) the Commissioner of Public Health; (13) the Commissioner of Mental Health and Addiction Services; and [(13)] (14) one representative, designated by the Commissioner of Emergency Services and Public Protection, from each of the divisions of Emergency
Management and Homeland Security, State Police, Scientific Services and State-Wide Emergency Telecommunications within the Department of Emergency Services and Public Protection. Said board shall convene quarterly and at such other times as the chairperson deems necessary.

Sec. 34. (NEW) (Effective October 1, 2022) (a) There is established a 9-8-8 Suicide Prevention Lifeline Fund to fund suicide prevention services provided through the National Suicide Prevention Lifeline. The fund shall be administered by the Department of Mental Health and Addiction Services. Moneys in the fund shall be used only for the following purposes: (1) To ensure the efficient routing of calls made to the 9-8-8 National Suicide Prevention Lifeline by persons in the state, and (2) to employ or contract with mental health personnel to directly respond to such calls and provide acute mental health crisis outreach and stabilization services in response to such calls.

(b) The following moneys shall be deposited in or transferred to the 9-8-8 Suicide Prevention Lifeline Fund: (1) The state-wide 9-8-8 fee assessed on subscribers under subsection (f) of this section; (2) any appropriation made by the General Assembly to the Department of Mental Health and Addiction Services for deposit in the fund; (3) any federal funds intended for the provision of services in the state related to the 9-8-8 National Suicide Prevention Lifeline; (4) any grants or gifts intended for deposit in the fund; (5) interest, premiums, gains or other earnings on the fund; and (6) moneys from any other source that are intended for the purposes described in subsection (a) of this section.

(c) Moneys remaining in the 9-8-8 Suicide Prevention Lifeline Fund (1) shall not revert to the General Fund at the end of any fiscal year and remain available in subsequent fiscal years for the purposes described in subsection (a) of this section, and (2) shall not be subject to transfer to any other fund, or to transfer, assignment or reassignment for any purpose other than the purposes described in subsection (a) of this section.

(d) Within a time period determined by the Commissioner of Mental Health and Addiction Services.
Health and Addiction Services to ensure the availability of funds for the fiscal year beginning July 1, 2023, and not later than April first of each fiscal year thereafter, the commissioner shall determine the amount of funding needed to accomplish the purposes of the 9-8-8 Suicide Prevention Lifeline Fund described in subsection (a) of this section. The commissioner shall take into consideration any remaining moneys in the fund. Not later than thirty days after determining such amount in 2023, and not later than May first of each fiscal year thereafter, the commissioner shall report on such funding to the Public Utilities Regulatory Authority.

(e) On or before January 1, 2024, and annually thereafter, the Commissioner of Mental Health and Addiction Services shall report on the deposits and expenditures of the 9-8-8 Suicide Prevention Lifeline Fund to the Federal Communications Commission and, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies, public health, human services and children.

(f) On or before June 1, 2023, and annually thereafter, the Public Utilities Regulatory Authority shall conduct a proceeding to determine the amount of the monthly fee to be assessed against each subscriber of the following: (1) Local telephone service; (2) commercial mobile radio service, as defined in 47 CFR 20.3; and (3) voice over Internet protocol service, as defined in section 28-30b of the general statutes, to fund suicide prevention services. The authority shall base such fee on the findings of the Commissioner of Mental Health and Addiction Services, taking into consideration any existing moneys available in the 9-8-8 Suicide Prevention Lifeline Fund. The authority shall not approve any fee greater than seventy-five cents per month per access line.

(g) Each telephone or telecommunications company providing local telephone service, each provider of commercial mobile radio service and each provider of voice over Internet protocol service shall assess against each subscriber the fee established by the authority pursuant to
subsection (f) of this section, which shall be remitted to the Office of the State Treasurer for deposit into the 9-8-8 Suicide Prevention Lifeline Fund not later than the fifteenth day of each month.

Sec. 35. (NEW) (Effective October 1, 2022) (a) As used in this section:

(1) "Consumer" means a person who purchases prepaid wireless telecommunications service in a retail transaction.

(2) "Prepaid wireless E 9-8-8 Suicide Prevention Lifeline Fund fee" means the fee that a seller collects from a consumer in an amount established under section 34 of this act.

(3) "Prepaid wireless telecommunications service" means a wireless telephone service that a consumer pays for in advance, that allows the consumer to access the E 9-8-8 system by dialing or otherwise accessing the digits "9-8-8", and that is sold in predetermined units or dollars and such units or dollars decline with use.

(4) "Provider" means any person who provides prepaid wireless telecommunications service pursuant to a license issued by the Federal Communications Commission.

(5) "Retail transaction" means a purchase of prepaid wireless telecommunications service from a seller for any purpose other than resale.

(6) "Seller" means a person who sells prepaid wireless telecommunications service to a consumer.

(7) "Voice over Internet protocol service" or "VOIP" means a service that has the following characteristics: (A) Enables real-time, two-way voice communication; (B) requires a broadband connection from the users' locations; (C) requires IP-compatible customer premises equipment; and (D) allows subscribers generally to receive calls that originate on the public switched telephone network and to terminate calls on the public switched telephone.
(8) "Voice over Internet protocol service provider" or "VOIP service provider" means a company that provides VOIP telephone service.

(9) "Wireless telecommunications service" means commercial mobile radio service, as defined in 47 CFR 20.3, as from time to time amended.

(b) Each consumer shall be assessed a prepaid wireless 9-8-8 Suicide Prevention Lifeline Fund fee. Said fee shall be equal to the fee determined by the Public Utilities Regulatory Authority in accordance with subsection (f) of section 34 of this act for each retail transaction. For the purposes of this section, if a consumer purchase includes multiple prepaid wireless telecommunications services, each such individual service shall constitute a retail transaction.

(c) Any seller who is a party to a retail transaction within this state with a consumer shall collect the fee described in subsection (f) of section 34 of this act from such consumer for each such retail transaction. The seller shall disclose to the consumer the amount of such assessed fee in an invoice, a receipt or other similar document, or post such amount conspicuously on the seller's Internet web site or on a sign conspicuously displayed to the consumer at the point of sale.

(d) For the purposes of subsection (f) of section 34 of this act, a retail transaction made in the presence of the consumer at the place of business of the seller shall be treated as occurring within this state if such place of business is within the state, and any other retail transaction shall be treated as occurring in this state if the retail transaction is treated as occurring in this state under subdivision (2) of subsection (a) of section 12-407 of the general statutes for the purposes of the sales and use tax.

(e) The consumer shall be liable for any prepaid wireless 9-8-8 Suicide Prevention Lifeline Fund fee. There shall be no liability on the part of the seller or provider, except the seller shall be liable to remit any prepaid wireless 9-8-8 Suicide Prevention Lifeline Fund fees that the seller collects from any consumer, including, but not limited to, any such fee that the seller is required to collect but does not separately state on
an invoice, receipt or other similar document provided to the consumer, as required by subsection (f) of section 34 of this act.

(f) The amount of the prepaid wireless 9-8-8 Suicide Prevention Lifeline Fund fee that a seller collects from a consumer shall not be included in the base for measuring any tax, fee, surcharge or other charge that the state, any political subdivision of the state or any intergovernmental agency imposes on such seller, provided the seller separately stated such amount on an invoice, receipt or other similar document provided to the consumer.

Sec. 36. Section 19a-638 of the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage):

(a) A certificate of need issued by the unit shall be required for:

(1) The establishment of a new health care facility, except as provided in subdivision (23) of subsection (b) of this section;

(2) A transfer of ownership of a health care facility;

(3) A transfer of ownership of a large group practice to any entity other than a (A) physician, or (B) group of two or more physicians, legally organized in a partnership, professional corporation or limited liability company formed to render professional services and not employed by or an affiliate of any hospital, medical foundation, insurance company or other similar entity;

(4) The establishment of a freestanding emergency department;

(5) The termination of inpatient or outpatient services offered by a hospital, including, but not limited to, the termination by a short-term acute care general hospital or children's hospital of inpatient and outpatient mental health and substance abuse services;

(6) The establishment of an outpatient surgical facility, as defined in section 19a-493b, or as established by a short-term acute care general hospital;
(7) The termination of surgical services by an outpatient surgical facility, as defined in section 19a-493b, or a facility that provides outpatient surgical services as part of the outpatient surgery department of a short-term acute care general hospital, provided termination of outpatient surgical services due to (A) insufficient patient volume, or (B) the termination of any subspecialty surgical service, shall not require certificate of need approval;

(8) The termination of an emergency department by a short-term acute care general hospital;

(9) The establishment of cardiac services, including inpatient and outpatient cardiac catheterization, interventional cardiology and cardiovascular surgery;

(10) The acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners, by any person, physician, provider, short-term acute care general hospital or children's hospital, except (A) as provided for in subdivision (22) of subsection (b) of this section, and (B) a certificate of need issued by the unit shall not be required where such scanner is a replacement for a scanner that was previously acquired through certificate of need approval or a certificate of need determination;

(11) The acquisition of nonhospital based linear accelerators;

(12) An increase in the licensed bed capacity of a health care facility, except as provided in subdivision (23) of subsection (b) of this section;

(13) The acquisition of equipment utilizing technology that has not previously been utilized in the state;

(14) An increase of two or more operating rooms within any three-year period, commencing on and after October 1, 2010, by an outpatient surgical facility, as defined in section 19a-493b, or by a short-term acute care general hospital; and
(15) The termination of inpatient or outpatient services offered by a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended.

(b) A certificate of need shall not be required for:

(1) Health care facilities owned and operated by the federal government;

(2) The establishment of offices by a licensed private practitioner, whether for individual or group practice, except when a certificate of need is required in accordance with the requirements of section 19a-493b or subdivision (3), (10) or (11) of subsection (a) of this section;

(3) A health care facility operated by a religious group that exclusively relies upon spiritual means through prayer for healing;

(4) Residential care homes, as defined in subsection (c) of section 19a-490, and nursing homes and rest homes, as defined in subsection (o) of section 19a-490;

(5) An assisted living services agency, as defined in section 19a-490;

(6) Home health agencies, as defined in section 19a-490;

(7) Hospice services, as described in section 19a-122b;

(8) Outpatient rehabilitation facilities;

(9) Outpatient chronic dialysis services;

(10) Transplant services;

(11) Free clinics, as defined in section 19a-630;

(12) School-based health centers and expanded school health sites, as such terms are defined in section 19a-6r, community health centers, as defined in section 19a-490a, not-for-profit outpatient clinics licensed in accordance with the provisions of chapter 368v and federally qualified
A program licensed or funded by the Department of Children and Families, provided such program is not a psychiatric residential treatment facility;

Any nonprofit facility, institution or provider that has a contract with, or is certified or licensed to provide a service for, a state agency or department for a service that would otherwise require a certificate of need. The provisions of this subdivision shall not apply to a short-term acute care general hospital or children's hospital, or a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended;

A health care facility operated by a nonprofit educational institution exclusively for students, faculty and staff of such institution and their dependents;

An outpatient clinic or program operated exclusively by or contracted to be operated exclusively by a municipality, municipal agency, municipal board of education or a health district, as described in section 19a-241;

A residential facility for persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disabilities;

Replacement of existing imaging equipment if such equipment was acquired through certificate of need approval or a certificate of need determination, provided a health care facility, provider, physician or person notifies the unit of the date on which the equipment is replaced and the disposition of the replaced equipment;

Acquisition of cone-beam dental imaging equipment that is to be used exclusively by a dentist licensed pursuant to chapter 379;
(20) The partial or total elimination of services provided by an outpatient surgical facility, as defined in section 19a-493b, except as provided in subdivision (6) of subsection (a) of this section and section 19a-639e;

(21) The termination of services for which the Department of Public Health has requested the facility to relinquish its license; or

(22) Acquisition of any equipment by any person that is to be used exclusively for scientific research that is not conducted on humans; or

(23) On or before June 30, 2026, the establishment of a new mental health facility or an increase in the licensed bed capacity of a mental health facility, provided the mental health facility accepts reimbursement for any covered benefit provided to a covered individual under: (A) An individual or group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469; (B) a self-insured employee welfare benefit plan established pursuant to the federal Employee Retirement Income Security Act of 1974, as amended from time to time; or (C) HUSKY Health, as defined in section 17b-290.

(c) (1) Any person, health care facility or institution that is unsure whether a certificate of need is required under this section, or (2) any health care facility that proposes to relocate pursuant to section 19a-639c shall send a letter to the unit that describes the project and requests that the unit make a determination as to whether a certificate of need is required. In the case of a relocation of a health care facility, the letter shall include information described in section 19a-639c. A person, health care facility or institution making such request shall provide the unit with any information the unit requests as part of its determination process.

(d) The executive director of the Office of Health Strategy may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the executive director holds a
public hearing prior to implementing the policies and procedures and
posts notice of intent to adopt regulations on the office's Internet web
site and the eRegulations System not later than twenty days after the
date of implementation. Policies and procedures implemented pursuant
to this section shall be valid until the time final regulations are adopted.

(e) On or before September 1, 2022, the executive director of the Office
of Health Strategy shall develop procedures by which a person or entity
shall notify said office of such person's or entity's intent to (1) establish
a new mental health facility, or (2) increase the licensed bed capacity at
a mental health facility, without applying for a certificate of need as
permitted pursuant to subdivision (23) of subsection (b) of this section.
Such procedures shall include a requirement that the person or entity
intending to establish such a facility or to increase the licensed bed
capacity at such a facility notify said office of the address of such facility
and a description of all services that are being or will be provided at
such facility. Not less than once every six months after establishing such
facility or increasing the licensed bed capacity at such facility, the owner
or operator of such facility shall report to the executive director of said
office regarding the care being provided at such facility and, where
available, the demographics of persons receiving services from such
facility, including, but not limited to, the number of such persons and
such persons' age and town, city or borough of residence.

Sec. 37. (NEW) (Effective from passage) (a) On or before October 1, 2022,
the Commissioner of Children and Families shall establish a grant
program to assist families with the cost of obtaining (1) a drug or
treatment prescribed for a child by a health care provider for treatment
of a mental or behavioral health condition, which drug or treatment has
not been approved by the federal Food and Drug Administration for
treatment of the mental or behavioral condition, if the cost of such drug
or treatment is not covered by insurance or Medicaid, and (2) intensive
evidence-based services or other intensive services to treat mental and
behavioral health conditions in children and adolescents, including, but
not limited to, intensive in-home child and adolescent psychiatric
services and services provided by an intensive outpatient program, if
the cost of such services is not covered by insurance or Medicaid. The commissioner shall administer and establish eligibility requirements for the grant program in consultation with the Commissioner of Consumer Protection. Such eligibility requirements may include, but need not be limited to, a family's financial need. The Commissioner of Children and Families, in consultation with the Commissioner of Consumer Protection, shall determine the amount of each grant. An eligible family may apply for a grant under such program to the secretary, at such time and in such manner as the Commissioner of Children and Families prescribes.

(b) The Departments of Children and Families and Consumer Protection and the Office of Policy and Management shall post in a conspicuous location on their respective Internet web sites a description of the grant program, including, but not limited to, eligibility requirements and the application process for such grant program. The Secretary of the Office of Policy and Management may request that another state agency post such description on such agency's Internet web site.

Sec. 38. (NEW) (Effective from passage) On or before January 1, 2023, the Department of Public Health shall develop or procure, in consultation with a representative of a children's hospital located in the state and the Connecticut chapter of a national professional association of pediatricians and of a national professional association of child and adolescent psychiatrists, a pediatric mental health, behavioral health and substance use disorder screening tool to be completed by a child and, where appropriate, the child's parent or guardian prior to or during the child's appointment with the child's pediatrician or during the child's visit to an emergency department. Such screening tool shall include questions geared toward assisting the pediatrician or emergency department physician in diagnosing common mental health and behavioral health conditions and substance use disorders that may require specialized treatment. On or before January 1, 2023, the Department of Public Health, in collaboration with the Departments of Children and Families and Mental Health and Addiction Services, shall
make the screening tool available to all pediatricians and emergency
department physicians in the state, free of charge, and make
recommendations to pediatricians and emergency department
physicians for its effective use. Pediatricians and emergency department
physicians shall use the screening tool developed pursuant to this
section as a supplement to the existing methods used to diagnose a
mental health or behavioral health condition or a substance use
disorder. Pediatricians shall provide such screening tool to each patient
on an annual basis. Emergency department physicians shall provide
such screening tool to each emergency department patient under the age
of eighteen, or the parents or guardian of such patient, prior to such
patient's discharge from the emergency department and, to the extent
possible and as soon as practicable, send a copy of such tool to such
patient's pediatrician or primary care provider.

Sec. 39. Section 38a-492b of the general statutes is repealed and the
following is substituted in lieu thereof (Effective January 1, 2023):

(a) For the purposes of this section:

(1) "Mental or nervous conditions" has the same meaning as provided
in section 38a-488a, as amended by this act.

(2) (A) "Peer-reviewed medical literature" means a published study
in a journal or other publication in which original manuscripts have
been critically reviewed for scientific accuracy, validity and reliability
by unbiased international experts, and that has been determined by the
International Committee of Medical Journal Editors to have met its
Uniform Requirements for Manuscripts Submitted to Biomedical
Journals.

(B) "Peer-reviewed medical literature" does not mean publications or
supplements to publications that are sponsored to a significant extent
by a pharmaceutical manufacturing company or any health insurer,
health care center, hospital service corporation, medical service
corporation or fraternal benefit society that delivers, issues for delivery,
renews, amends or continues a health insurance policy in this state.
(a) (b) (1) Each individual health insurance policy delivered, issued for delivery, renewed, amended or continued in this state, that provides coverage for prescription drugs approved by the federal Food and Drug Administration for treatment of certain types of cancer, mental or nervous conditions or other disabling or life-threatening chronic diseases or conditions, shall not exclude coverage of any such drug on the basis that such drug has been prescribed for the treatment of a type of cancer, a mental or nervous condition or another disabling or life-threatening chronic disease or condition for which the drug has not been approved by the federal Food and Drug Administration, provided the drug is recognized for treatment of the specific type of cancer, mental or nervous condition or another disabling or life-threatening chronic disease or condition for which the drug has been prescribed in one of the following established reference compendia or in peer-reviewed medical literature generally recognized by the relevant medical community: (A) The U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional; (B) The American Medical Association's Drug Evaluations; or (C) The American Society of Health-System Pharmacists' American Hospital Formulary Service Drug Information. [As used in this section, "peer-reviewed medical literature" means a published study in a journal or other publication in which original manuscripts have been critically reviewed for scientific accuracy, validity and reliability by unbiased international experts, and that has been determined by the International Committee of Medical Journal Editors to have met its Uniform Requirements for Manuscripts Submitted to Biomedical Journals. "Peer-reviewed medical literature" does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or any health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society that delivers, issues for delivery, renews, amends or continues a health insurance policy in this state.]

(2) The coverage required under subdivision (1) of this subsection shall include medically necessary services associated with the administration of such drug.
(3) A drug use covered under subdivision (1) of this subsection shall not be denied based on medical necessity except for reasons that are unrelated to the legal status of the drug use.

[(b)] (c) Nothing in subsection [(a)] (b) of this section shall be construed to require coverage for: (1) [any] Any drug used in a research trial sponsored by a drug manufacturer or a government entity; [(2) any drug or service furnished in a research trial if the research trial sponsor furnishes the drug or service to an insured participating in such trial without charge; [(3) any] any drug that the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer, mental or nervous condition or other disabling or life-threatening chronic disease or condition for which the drug has been prescribed.

[(c)] (d) Except as specified, nothing in this section shall be construed to create, impair, limit or modify authority to provide reimbursement for drugs used in the treatment of any other disease or condition.

Sec. 40. Section 38a-518b of the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2023):

(a) For the purposes of this section:

(1) "Mental or nervous conditions" has the same meaning as provided in section 38a-514, as amended by this act.

(2) (A) "Peer-reviewed medical literature" means a published study in a journal or other publication in which original manuscripts have been critically reviewed for scientific accuracy, validity and reliability by unbiased international experts, and that has been determined by the International Committee of Medical Journal Editors to have met its Uniform Requirements for Manuscripts Submitted to Biomedical Journals.

(B) "Peer-reviewed medical literature" does not mean publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or any health insurer,
health care center, hospital service corporation, medical service corporation or fraternal benefit society that delivers, issues for delivery, renews, amends or continues a health insurance policy in this state.

[(a)] (b) (1) Each group health insurance policy delivered, issued for delivery, renewed, amended or continued in this state, that provides coverage for prescription drugs approved by the federal Food and Drug Administration for treatment of certain types of cancer, mental or nervous conditions or other disabling or life-threatening chronic diseases or conditions, shall not exclude coverage of any such drug on the basis that such drug has been prescribed for the treatment of a type of cancer, a mental or nervous condition or [a] another disabling or life-threatening chronic disease or condition for which the drug has not been approved by the federal Food and Drug Administration, provided the drug is recognized for treatment of the specific type of cancer, mental or nervous condition or [a] other disabling or life-threatening chronic disease or condition for which the drug has been prescribed in one of the following established reference compendia or in peer-reviewed medical literature generally recognized by the relevant medical community: (A) The U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional; (B) The American Medical Association's Drug Evaluations; or (C) The American Society of Health-System Pharmacists' American Hospital Formulary Service Drug Information. [As used in this section, "peer-reviewed medical literature" means a published study in a journal or other publication in which original manuscripts have been critically reviewed for scientific accuracy, validity and reliability by unbiased international experts, and that has been determined by the International Committee of Medical Journal Editors to have met its Uniform Requirements for Manuscripts Submitted to Biomedical Journals. "Peer-reviewed medical literature" does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or any health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society that delivers, issues for delivery, renews, amends or continues a health insurance policy in this state.]
(2) The coverage required under subdivision (1) of this subsection shall include medically necessary services associated with the administration of such drug.

(3) A drug use covered under subdivision (1) of this subsection shall not be denied based on medical necessity except for reasons that are unrelated to the legal status of the drug use.

([(b)] (c) Nothing in subsection [(a)] (b) of this section shall be construed to require coverage for; (1) [any] Any drug used in a research trial sponsored by a drug manufacturer or a government entity; [.] (2) any drug or service furnished in a research trial if the research trial sponsor furnishes the drug or service to an insured participating in such trial without charge; [.] or (3) any drug that the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer, mental or nervous condition or [a] other disabling or life-threatening chronic disease or condition for which the drug has been prescribed.

([(c)] (d) Except as specified, nothing in this section shall be construed to create, impair, limit or modify authority to provide reimbursement for drugs used in the treatment of any other disease or condition.

Sec. 41. (NEW) (Effective July 1, 2022) (a) As used in this section and section 42 of this act, "designated staff member" means a teacher, school administrator, guidance counselor, school counselor, psychologist, social worker, nurse, physician or school paraeducator employed by a local or regional board of education or working in a public middle school or high school.

(b) Not later than January 1, 2023, the Department of Children and Families shall, in collaboration with the Department of Education, develop a peer-to-peer mental health support program that provides services to aid students in grades six to twelve, inclusive, in problem solving, decision making, conflict resolution and stress management. Such program shall be made available to local and regional boards of education, local health departments, district departments of health,
youth services bureaus established pursuant to section 10-19m of the
general statutes, municipal social service agencies and other youth-
serving organizations approved by the Department of Children and
Families. In developing such program, the department shall utilize best
practices and may use existing models of peer-to-peer counseling.

(c) On and after January 1, 2023, the Department of Children and
Families shall, in collaboration with the Department of Education,
provide training to (1) designated staff members selected by the
superintendent of schools pursuant to section 42 of this act, and (2)
employees of local health departments, district departments of health,
youth service bureaus established pursuant to section 10-19m of the
general statutes, municipal social service agencies and other youth-
serving organizations selected pursuant to section 43 of this act, on how
to implement the program and provide instruction, guidance and
supervision to students participating in the program.

Sec. 42. (NEW) (Effective July 1, 2022) For the school year commencing
July 1, 2023, and each school year thereafter, any local and regional
board of education, in collaboration with the Departments of Children
and Families and Education, may administer the peer-to-peer mental
health support program developed pursuant to section 41 of this act.
The superintendent of schools for each local or regional school district
administering the program shall select one or more designated staff
members to complete the training described in section 41 of this act. The
program shall be provided to participating students in grades six to
twelve, inclusive.

Sec. 43. (NEW) (Effective July 1, 2022) On and after July 1, 2023, any
local health department, district department of health, youth service
bureau established pursuant to section 10-19m of the general statutes,
municipal social service agency or other youth-serving organization
approved by the Department of Children and Families, in collaboration
with the Department of Education, may administer the peer-to-peer
mental health support program developed pursuant to section 41 of this
act. The entity administering the program shall select one or more
employees to complete the training described in section 41 of this act. The program shall be provided to participating students in grades six to twelve, inclusive.

Sec. 44. (NEW) (Effective July 1, 2022) (a) For purposes of this section, (1) "children with behavioral health needs" means children who are suffering from one or more mental disorders as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", and (2) "in-home respite care services" means in-home care for children with behavioral health needs, provided in order to afford such children's parents or guardians respite from caregiving.

(b) There is established an account to be known as the "Department of Children and Families in-home respite care services fund" which shall be a separate, nonlapsing account within the General Fund. The account shall contain any moneys required by law to be deposited in the account. Moneys in the account shall be expended by the Commissioner of Children and Families for the purposes of funding the in-home respite care services program established pursuant to subsection (c) of this section.

(c) Not later than January 1, 2023, the Commissioner of Children and Families shall establish a program to provide in-home respite care services. Such program shall be administered by the Department of Children and Families, through contracts for services with providers of such services, or by means of direct subsidy to the parents and guardians of such children to enable such parents and guardians to purchase such services.

(d) The Commissioner of Children and Families shall adopt regulations in accordance with the provisions of chapter 54 to implement the provisions of this section, including, but not limited to, eligibility criteria for participation in the in-home respite care services program.

Sec. 45. (NEW) (Effective July 1, 2022) (a) For the fiscal year ending
June 30, 2023, and each fiscal year thereafter, the Connecticut Higher Education Supplemental Loan Authority, in consultation with the Department of Public Health, shall administer, within available appropriations, a mental health care provider loan forgiveness program to persons who meet the eligibility requirements described in subsection (b) of this section.

(b) The mental health care provider loan forgiveness program shall provide student loan forgiveness to any mental health care provider licensed pursuant to chapter 370, 382a, 383, 383a, 383b, or 383c of the general statutes, or section 20-195aaa, 20-195ggg or 20-195mmm of the general statutes who (1) is a resident of the state or establishes residency in the state not later than five years after the date on which such provider submitted his or her application for loan forgiveness under such program, provided at least thirty-three per cent of program recipients shall have established residency in the state not later than five years after the date on which they submitted such application, (2) provides mental health care services primarily to residents of the state who are eighteen years of age or younger, (3) is employed, at the time the mental health care provider applies for consolidation of his or her educational loans under subdivision (4) of this subsection, in an area designated by the Commissioner of Public Health as a mental health care provider shortage area, (4) (A) consolidates his or her federal or state educational loans through the Connecticut Higher Education Supplemental Loan Authority, and (B) completes one hundred twenty consecutive on-time payments of the consolidation loan under an income-driven repayment plan. A mental health care provider may change employment or licensure after applying for loan consolidation or loan forgiveness under this section and receive loan forgiveness pursuant to subsection (c) of this section, provided the mental health care provider satisfies the eligibility requirements of this subsection.

(c) The Connecticut Higher Education Supplemental Loan Authority shall forgive any balance on the consolidation loan of any mental health care provider who satisfies the eligibility requirements prescribed in subsection (b) of this section.
(d) Mental health care providers may apply to the Connecticut Higher Education Supplemental Loan Authority for consolidation of federal or state educational loans or for loan forgiveness under this section at such time and in such manner as the executive director of the Connecticut Higher Education Supplemental Loan Authority prescribes.

Sec. 46. (NEW) (Effective from passage) On or before January 1, 2023, the Department of Public Health shall establish and administer a child psychiatrist grant program. The program shall provide incentive grants to employers of child psychiatrists for recruiting and hiring new child psychiatrists and retaining child psychiatrists who are in their employ. The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, for the administration of this section, including the establishment of eligibility requirements, priority categories, funding limitations and the application process for the grant program.

Sec. 47. (NEW) (Effective from passage) On or before January 1, 2023, the Department of Mental Health and Addiction Services, in collaboration with the Department of Children and Families, shall (1) provide for the design, plan and implementation of a multiyear, statewide advertising campaign, including, but not limited to, television, radio and Internet web site advertisements, promoting the availability of all of the mental health, behavioral health and substance use disorder services in the state, including, but not limited to, the difference between 9-1-1, 9-8-8 and 2-1-1, and informing residents how to obtain such services, and (2) establish and regularly update an Internet web site connected with such advertising campaign that includes, but is not limited to, a comprehensive listing of providers of mental health, behavioral health and substance use disorder services in the state. The commissioner shall solicit cooperation and participation from such providers in such advertising campaign, including, but not limited to, soliciting any available funds.

Sec. 48. (NEW) (Effective from passage) On or before January 1, 2023,
the Department of Children and Families, in collaboration with the
Department of Mental Health and Addiction Services, shall establish a
grant program to provide funding to inpatient and outpatient mental
and behavioral health care programs that treat children for the creation
of a parent and caregiver peer-to-peer support program for parents and
caregivers of children with mental and behavioral health issues. The
Commissioner of Children and Families shall adopt regulations, in
accordance with the provisions of chapter 54 of the general statutes, for
the administration of this section, including the establishment of
eligibility requirements, priority categories, funding limitations and the
application process for the grant program.

Sec. 49. (NEW) (Effective January 1, 2023) Each individual health
insurance policy providing coverage of the type specified in
subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
statutes delivered, issued for delivery, renewed, amended or continued
in this state shall provide coverage for therapy that a health care
provider licensed in this state and acting within the provider's scope of
practice provides to an insured for the purpose of improving the
insured's mental health and preventing mental or nervous conditions.
For the purposes of this section, "mental or nervous conditions" has the
same meaning as provided in section 38a-488a of the general statutes, as
amended by this act.

Sec. 50. (NEW) (Effective January 1, 2023) Each group health insurance
policy providing coverage of the type specified in subdivisions (1), (2),
(4), (11) and (12) of section 38a-469 of the general statutes delivered,
issued for delivery, renewed, amended or continued in this state shall
provide coverage for therapy that a health care provider licensed in this
state and acting within the provider's scope of practice provides to an
insured for the purpose of improving the insured's mental health and
preventing mental or nervous conditions. For the purposes of this
section, "mental or nervous conditions" has the same meaning as
provided in section 38a-514 of the general statutes, as amended by this
act.
Sec. 51. Section 38a-488a of the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2023):

(a) For the purposes of this section:

(1) (A) "Mental or nervous conditions" means mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

(B) "Mental or nervous conditions" does not include [(A)] (i) intellectual disability, [(B)] (ii) specific learning disorders, [(C)] (iii) motor disorders, [(D)] (iv) communication disorders, [(E)] (v) caffeine-related disorders, [(F)] (vi) relational problems, and [(G)] (vii) other conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

(2) ["benefits payable"] "Benefits payable" means the usual, customary and reasonable charges for treatment deemed necessary under generally accepted medical standards, except that in the case of a managed care plan, as defined in section 38a-478, "benefits payable" means the payments agreed upon in the contract between a managed care organization, as defined in section 38a-478, and a provider, as defined in section 38a-478.

(3) ["acute treatment services"] "Acute treatment services" means twenty-four-hour medically supervised treatment for a substance use disorder, that is provided in a medically managed or medically monitored inpatient facility.

(4) ["clinical stabilization services"] "Clinical stabilization services" means twenty-four-hour clinically managed postdetoxification treatment, including, but not limited to, relapse prevention, family outreach, aftercare planning and addiction education and counseling.

(b) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for the diagnosis and treatment of mental or nervous conditions. Benefits payable include, but need not be limited to:

(1) General inpatient hospitalization, including in state-operated facilities;

(2) Medically necessary acute treatment services and medically necessary clinical stabilization services;

(3) General hospital outpatient services, including at state-operated facilities;

(4) Psychiatric inpatient hospitalization, including in state-operated facilities;

(5) Psychiatric outpatient hospital services, including at state-operated facilities;

(6) Intensive outpatient services, including at state-operated facilities;

(7) Partial hospitalization, including at state-operated facilities;

(8) Intensive, [home-based] evidence-based services or other intensive services, including, but not limited to, home-based services, designed to address specific mental or nervous conditions in a child or adolescent;

(9) Evidence-based family-focused therapy that specializes in the treatment of juvenile substance use disorders;

(10) Short-term family therapy intervention;

(11) Nonhospital inpatient detoxification;

(12) Medically monitored detoxification;

(13) Ambulatory detoxification;

(14) Inpatient services at psychiatric residential treatment facilities;
(15) Rehabilitation services provided in residential treatment facilities, general hospitals, psychiatric hospitals or psychiatric facilities;
(16) Observation beds in acute hospital settings;
(17) Psychological and neuropsychological testing conducted by an appropriately licensed health care provider;
(18) Trauma screening conducted by a licensed behavioral health professional;
(19) Depression screening, including maternal depression screening, conducted by a licensed behavioral health professional;
(20) Substance use screening conducted by a licensed behavioral health professional;
(c) No such policy shall establish any terms, conditions or benefits that place a greater financial burden on an insured for access to diagnosis or treatment of mental or nervous conditions than for diagnosis or treatment of medical, surgical or other physical health conditions, or prohibit an insured from obtaining or a health care provider from being reimbursed for multiple screening services as part of a single-day visit to a health care provider or a multicare institution, as defined in section 19a-490.
(d) In the case of benefits payable for the services of a licensed physician, such benefits shall be payable for the same services when such services are lawfully rendered by a psychologist licensed under the provisions of chapter 383 or by such a licensed psychologist in a licensed hospital or clinic or an advanced practice registered nurse licensed under the provisions of chapter 378.
(e) In the case of benefits payable for the services of a licensed physician or psychologist, such benefits shall be payable for the same services when such services are rendered by:
(1) A clinical social worker who is licensed under the provisions of
chapter 383b and who has passed the clinical examination of the
American Association of State Social Work Boards and has completed
at least two thousand hours of post-master's social work experience in a
nonprofit agency qualifying as a tax-exempt organization under Section
501(c) of the Internal Revenue Code of 1986 or any subsequent
corresponding internal revenue code of the United States, as from time
to time amended, in a municipal, state or federal agency or in an
institution licensed by the Department of Public Health under section
19a-490;

(2) A social worker who was certified as an independent social
worker under the provisions of chapter 383b prior to October 1, 1990;

(3) A licensed marital and family therapist who has completed at least
two thousand hours of post-master's marriage and family therapy work
experience in a nonprofit agency qualifying as a tax-exempt
organization under Section 501(c) of the Internal Revenue Code of 1986
or any subsequent corresponding internal revenue code of the United
States, as from time to time amended, in a municipal, state or federal
agency or in an institution licensed by the Department of Public Health
under section 19a-490;

(4) A marital and family therapist who was certified under the
provisions of chapter 383a prior to October 1, 1992;

(5) A licensed alcohol and drug counselor, as defined in section 20-
74s, or a certified alcohol and drug counselor, as defined in section 20-
74s;

(6) A licensed professional counselor; or

(7) An advanced practice registered nurse licensed under the
provisions of chapter 378.

(f) (1) In the case of benefits payable for the services of a licensed
physician, such benefits shall be payable for (A) services rendered in a
child guidance clinic or residential treatment facility by a person with a
master's degree in social work or by a person with a master's degree in
marriage and family therapy under the supervision of a psychiatrist,
physician, licensed marital and family therapist, or licensed clinical
social worker who is eligible for reimbursement under subdivisions (1)
to (4), inclusive, of subsection (e) of this section; (B) services rendered in
a residential treatment facility by a licensed or certified alcohol and drug
counselor who is eligible for reimbursement under subdivision (5) of
subsection (e) of this section; (C) services rendered in a residential
treatment facility by a licensed professional counselor who is eligible for
reimbursement under subdivision (6) of subsection (e) of this section; or
(D) services rendered in a residential treatment facility by a licensed
advanced practice registered nurse who is eligible for reimbursement
under subdivision (7) of subsection (e) of this section.

(2) In the case of benefits payable for the services of a licensed
psychologist under subsection (e) of this section, such benefits shall be
payable for (A) services rendered in a child guidance clinic or residential
treatment facility by a person with a master's degree in social work or
by a person with a master's degree in marriage and family therapy
under the supervision of such licensed psychologist, licensed marital
and family therapist, or licensed clinical social worker who is eligible for
reimbursement under subdivisions (1) to (4), inclusive, of subsection (e)
of this section; (B) services rendered in a residential treatment facility by
a licensed or certified alcohol and drug counselor who is eligible for
reimbursement under subdivision (5) of subsection (e) of this section;
(C) services rendered in a residential treatment facility by a licensed
professional counselor who is eligible for reimbursement under
subdivision (6) of subsection (e) of this section; or (D) services rendered
in a residential treatment facility by a licensed advanced practice
registered nurse who is eligible for reimbursement under subdivision
(7) of subsection (e) of this section.

(g) In the case of benefits payable for the service of a licensed
physician practicing as a psychiatrist or a licensed psychologist, under
subsection (e) of this section, such benefits shall be payable for
outpatient services rendered (1) in a nonprofit community mental health
center, as defined by the Department of Mental Health and Addiction
Services, in a nonprofit licensed adult psychiatric clinic operated by an accredited hospital or in a residential treatment facility; (2) under the supervision of a licensed physician practicing as a psychiatrist, a licensed psychologist, a licensed marital and family therapist, a licensed clinical social worker, a licensed or certified alcohol and drug counselor, a licensed professional counselor or a licensed advanced practice registered nurse who is eligible for reimbursement under subdivisions (1) to (7), inclusive, of subsection (e) of this section; and (3) within the scope of the license issued to the center or clinic by the Department of Public Health or to the residential treatment facility by the Department of Children and Families.

(h) Except in the case of emergency services or in the case of services for which an individual has been referred by a physician or an advanced practice registered nurse affiliated with a health care center, nothing in this section shall be construed to require a health care center to provide benefits under this section through facilities that are not affiliated with the health care center.

(i) In the case of any person admitted to a state institution or facility administered by the Department of Mental Health and Addiction Services, Department of Public Health, Department of Children and Families or the Department of Developmental Services, the state shall have a lien upon the proceeds of any coverage available to such person or a legally liable relative of such person under the terms of this section, to the extent of the per capita cost of such person's care. Except in the case of emergency services, the provisions of this subsection shall not apply to coverage provided under a managed care plan, as defined in section 38a-478.

(j) Reimbursement for covered services rendered in this state by an out-of-network health care provider for the diagnosis or treatment of a substance use disorder shall be paid under the insured's individual health insurance policy directly to the provider if the provider is otherwise eligible for reimbursement for such services. The insured who received such services shall be deemed to have made an assignment to
such provider of such insured's coverage reimbursement benefits and other rights under the policy. In no event shall such provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against the insured for such services, except that such provider may collect any copayments, deductibles or other out-of-pocket expenses that the insured is required to pay under the policy.

Sec. 52. Section 38a-514 of the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2023):

(a) For the purposes of this section:

(1) (A) "Mental or nervous conditions" means mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

(B) "Mental or nervous conditions" does not include [(A)] (i) intellectual disability, [(B)] (ii) specific learning disorders, [(C)] (iii) motor disorders, [(D)] (iv) communication disorders, [(E)] (v) caffeine-related disorders, [(F)] (vi) relational problems, and [(G)] (vii) other conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". []

(2) ["benefits payable"] "Benefits payable" means the usual, customary and reasonable charges for treatment deemed necessary under generally accepted medical standards, except that in the case of a managed care plan, as defined in section 38a-478, "benefits payable" means the payments agreed upon in the contract between a managed care organization, as defined in section 38a-478, and a provider, as defined in section 38a-478. []

(3) ["acute treatment services"] "Acute treatment services" means twenty-four-hour medically supervised treatment for a substance use disorder, that is provided in a medically managed or medically
(4) ["clinical stabilization services"] "Clinical stabilization services" means twenty-four-hour clinically managed postdetoxification treatment, including, but not limited to, relapse prevention, family outreach, aftercare planning and addiction education and counseling.

(b) Except as provided in subsection (j) of this section, each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for the diagnosis and treatment of mental or nervous conditions. Benefits payable include, but need not be limited to:

(1) General inpatient hospitalization, including in state-operated facilities;

(2) Medically necessary acute treatment services and medically necessary clinical stabilization services;

(3) General hospital outpatient services, including at state-operated facilities;

(4) Psychiatric inpatient hospitalization, including in state-operated facilities;

(5) Psychiatric outpatient hospital services, including at state-operated facilities;

(6) Intensive outpatient services, including at state-operated facilities;

(7) Partial hospitalization, including at state-operated facilities;

(8) Intensive, [home-based] evidence-based services or other intensive services, including, but not limited to, home-based services, designed to address specific mental or nervous conditions in a child or adolescent;

(9) Evidence-based family-focused therapy that specializes in the
treatment of juvenile substance use disorders;

(10) Short-term family therapy intervention;

(11) Nonhospital inpatient detoxification;

(12) Medically monitored detoxification;

(13) Ambulatory detoxification;

(14) Inpatient services at psychiatric residential treatment facilities;

(15) Rehabilitation services provided in residential treatment facilities, general hospitals, psychiatric hospitals or psychiatric facilities;

(16) Observation beds in acute hospital settings;

(17) Psychological and neuropsychological testing conducted by an appropriately licensed health care provider;

(18) Trauma screening conducted by a licensed behavioral health professional;

(19) Depression screening, including maternal depression screening, conducted by a licensed behavioral health professional;

(20) Substance use screening conducted by a licensed behavioral health professional;

(c) No such group policy shall establish any terms, conditions or benefits that place a greater financial burden on an insured for access to diagnosis or treatment of mental or nervous conditions than for diagnosis or treatment of medical, surgical or other physical health conditions, or prohibit an insured from obtaining or a health care provider from being reimbursed for multiple screening services as part of a single-day visit to a health care provider or a multicare institution, as defined in section 19a-490.

(d) In the case of benefits payable for the services of a licensed physician, such benefits shall be payable for the same services when
such services are lawfully rendered by a psychologist licensed under the provisions of chapter 383 or by such a licensed psychologist in a licensed hospital or clinic.

(e) In the case of benefits payable for the services of a licensed physician or psychologist, such benefits shall be payable for the same services when such services are rendered by:

(1) A clinical social worker who is licensed under the provisions of chapter 383b and who has passed the clinical examination of the American Association of State Social Work Boards and has completed at least two thousand hours of post-master's social work experience in a nonprofit agency qualifying as a tax-exempt organization under Section 501(c) of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as from time to time amended, in a municipal, state or federal agency or in an institution licensed by the Department of Public Health under section 19a-490;

(2) A social worker who was certified as an independent social worker under the provisions of chapter 383b prior to October 1, 1990;

(3) A licensed marital and family therapist who has completed at least two thousand hours of post-master's marriage and family therapy work experience in a nonprofit agency qualifying as a tax-exempt organization under Section 501(c) of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as from time to time amended, in a municipal, state or federal agency or in an institution licensed by the Department of Public Health under section 19a-490;

(4) A marital and family therapist who was certified under the provisions of chapter 383a prior to October 1, 1992;

(5) A licensed alcohol and drug counselor, as defined in section 20-74s, or a certified alcohol and drug counselor, as defined in section 20-74s;
(6) A licensed professional counselor; or

(7) An advanced practice registered nurse licensed under the provisions of chapter 378.

(f) (1) In the case of benefits payable for the services of a licensed physician, such benefits shall be payable for (A) services rendered in a child guidance clinic or residential treatment facility by a person with a master's degree in social work or by a person with a master's degree in marriage and family therapy under the supervision of a psychiatrist, physician, licensed marital and family therapist or licensed clinical social worker who is eligible for reimbursement under subdivisions (1) to (4), inclusive, of subsection (e) of this section; (B) services rendered in a residential treatment facility by a licensed or certified alcohol and drug counselor who is eligible for reimbursement under subdivision (5) of subsection (e) of this section; or (C) services rendered in a residential treatment facility by a licensed professional counselor who is eligible for reimbursement under subdivision (6) of subsection (e) of this section.

(2) In the case of benefits payable for the services of a licensed psychologist under subsection (e) of this section, such benefits shall be payable for (A) services rendered in a child guidance clinic or residential treatment facility by a person with a master's degree in social work or by a person with a master's degree in marriage and family therapy under the supervision of such licensed psychologist, licensed marital and family therapist or licensed clinical social worker who is eligible for reimbursement under subdivisions (1) to (4), inclusive, of subsection (e) of this section; (B) services rendered in a residential treatment facility by a licensed or certified alcohol and drug counselor who is eligible for reimbursement under subdivision (5) of subsection (e) of this section; or (C) services rendered in a residential treatment facility by a licensed professional counselor who is eligible for reimbursement under subdivision (6) of subsection (e) of this section.

(g) In the case of benefits payable for the service of a licensed physician practicing as a psychiatrist or a licensed psychologist, under subsection (e) of this section, such benefits shall be payable for
outpatient services rendered (1) in a nonprofit community mental health center, as defined by the Department of Mental Health and Addiction Services, in a nonprofit licensed adult psychiatric clinic operated by an accredited hospital or in a residential treatment facility; (2) under the supervision of a licensed physician practicing as a psychiatrist, a licensed psychologist, a licensed marital and family therapist, a licensed clinical social worker, a licensed or certified alcohol and drug counselor, or a licensed professional counselor who is eligible for reimbursement under subdivisions (1) to (6), inclusive, of subsection (e) of this section; and (3) within the scope of the license issued to the center or clinic by the Department of Public Health or to the residential treatment facility by the Department of Children and Families.

(h) Except in the case of emergency services or in the case of services for which an individual has been referred by a physician affiliated with a health care center, nothing in this section shall be construed to require a health care center to provide benefits under this section through facilities that are not affiliated with the health care center.

(i) In the case of any person admitted to a state institution or facility administered by the Department of Mental Health and Addiction Services, Department of Public Health, Department of Children and Families or the Department of Developmental Services, the state shall have a lien upon the proceeds of any coverage available to such person or a legally liable relative of such person under the terms of this section, to the extent of the per capita cost of such person's care. Except in the case of emergency services the provisions of this subsection shall not apply to coverage provided under a managed care plan, as defined in section 38a-478.

(j) A group health insurance policy may exclude the benefits required by this section if such benefits are included in a separate policy issued to the same group by an insurance company, health care center, hospital service corporation, medical service corporation or fraternal benefit society. Such separate policy, which shall include the benefits required by this section and the benefits required by section 38a-533, shall not be
required to include any other benefits mandated by this title.

(k) In the case of benefits based upon confinement in a residential treatment facility, such benefits shall be payable in situations in which the insured has a serious mental or nervous condition that substantially impairs the insured's thoughts, perception of reality, emotional process or judgment or grossly impairs the behavior of the insured, and, upon an assessment of the insured by a physician, psychiatrist, psychologist or clinical social worker, cannot appropriately, safely or effectively be treated in an acute care, partial hospitalization, intensive outpatient or outpatient setting.

(l) The services rendered for which benefits are to be paid for confinement in a residential treatment facility shall be based on an individual treatment plan. For purposes of this section, the term "individual treatment plan" means a treatment plan prescribed by a physician with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

(m) Reimbursement for covered services rendered in this state by an out-of-network health care provider for the diagnosis or treatment of a substance use disorder shall be paid under the insured's group health insurance policy directly to the provider if the provider is otherwise eligible for reimbursement for such services. The insured who received such services shall be deemed to have made an assignment to such provider of such insured's coverage reimbursement benefits and other rights under the policy. In no event shall such provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against the insured for such services, except that such provider may collect any copayments, deductibles or other out-of-pocket expenses that the insured is required to pay under the policy.

Sec. 53. (Effective July 1, 2022) (a) As used in this section:

(1) "Mental health programming" means age-appropriate education or outreach initiatives aimed at students for the prevention of mental
illness, including, but not limited to, poster and flyer campaigns, films, guest speakers or other school events; and

(2) "School-based mental health clinic" means a clinic that: (A) Is located in, or on the grounds of, a school facility of a school district or school board or of an Indian tribe or tribal organization; (B) is organized through school, community and health provider relationships; (C) is administered by a sponsoring facility; and (D) provides on-site mental, emotional or behavioral health services to children and adolescents in accordance with state and local law, including laws relating to licensure and certification.

(b) Not later than January 1, 2023, the Departments of Children and Families, Public Health and Education, in consultation with the Connecticut Association of School-Based Health Centers and a children's mental health service provider licensed by the Department of Children and Families, shall develop a plan to promote access to mental health services for children and youth in regions of the state that do not have access to a school-based health center or an expanded school health site, which may include, but need not be limited to, establishing school-based mental health clinics. The mental health services included in such plan may include, but not be limited to, (1) to the extent permitted by a license or certification of a sponsoring facility, as defined in section 19a-6r of the general statutes, the provision of counseling to individual students, groups or families, (2) establishing the hours of operation of any school-based mental health clinic to include, in addition to school hours, after school, weekend or summer hours based on community need for services, and (3) the provision of mental health programming for students in partnership with a local or regional board of education.

(c) Any mental health service provider who staffs any school-based mental health clinic established in partnership with a local or regional board of education shall be knowledgeable about social-emotional learning, as defined in section 10-222v of the general statutes, and restorative practices and may receive additional training through participation in the social-emotional learning and restorative practices
training provided to teachers and administrators of the schools governed by such board.

(d) Not later than February 1, 2023, the Departments of Children and Families and Public Health shall jointly submit, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to children, a report on the (1) plan developed pursuant to subsection (b) of this section, and (2) availability of any sources of funding for the implementation of such plan.

Sec. 54. Section 20-188 of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2022):

Before granting a license to a psychologist, the department shall, except as provided in section 20-190, require any applicant therefor to pass an examination in psychology prescribed by the department with the advice and consent of the board. Each applicant shall pay a fee of five hundred sixty-five dollars, and shall satisfy the department that such applicant: (1) Has received the doctoral degree based on a program of studies whose content was primarily psychological from an educational institution approved in accordance with section 20-189, including, but not limited to, the completion of at least one semester-long clerkship at a facility licensed or operated by the Department of Children and Families, or for any other state agency as deemed appropriate by the Commissioner of Children and Families; and (2) has had at least one year's experience that meets the requirements established in regulations adopted by the department, in consultation with the board, in accordance with the provisions of chapter 54. The department shall establish a passing score for the examination with the consent of the board. Any certificate granted by the board of examiners prior to June 24, 1969, shall be deemed a valid license permitting continuance of profession subject to the provisions of this chapter. An applicant who is licensed or certified as a psychologist in another state, territory or commonwealth of the United States may substitute two years of licensed or certified work experience in the practice of
psychology, as defined in section 20-187a, in lieu of the requirements of subdivision (2) of this section. **As used in this section, "clerkship" means a program in which a doctoral degree candidate works as a psychological assessor or psychotherapist for between twelve and sixteen hours per week and during which the candidate was supervised by an agency-affiliated psychologist and at least one core faculty member of the doctoral degree program.**

Sec. 55. Section 19a-179f of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2022):

(a) A licensed or certified emergency medical services organization or provider may transport a patient by ambulance to an alternate destination, in consultation with the medical director of a sponsor hospital.

(b) On or before January 1, 2024, the Office of Emergency Medical Services shall develop protocols for a licensed or certified emergency medical services organization or provider to transport a pediatric patient with mental or behavioral health needs by ambulance to an urgent care center operated by the Department of Children and Families that is dedicated to treating children's urgent mental or behavioral health needs.

[(b) (c)] Any ambulance used for transport to an alternate destination under subsection (a) or (b) of this section shall meet the requirements for a basic level ambulance, as prescribed in regulations adopted pursuant to section 19a-179, including requirements concerning medically necessary supplies and services.

Sec. 56. (NEW) (Effective January 1, 2023) (a) For the purposes of this section:

(1) "Collaborative Care Model" means the Collaborative Care Model developed at the University of Washington;

(2) "CPT code" means a code number under the Current Procedural Terminology system developed by the American Medical Association;
and

(3) "HCPCS code" means a code number under the Healthcare Common Procedure Coding System developed by the federal Centers for Medicare and Medicaid Services.

(b) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes and delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2023, shall provide coverage for health care services that a primary care provider provides to an insured under the Collaborative Care Model. Such services shall include, but need not be limited to, services with a CPT code of 99484, 99492, 99493 or 99494 or HCPCS code of G2214, or any subsequent corresponding code.

Sec. 57. (NEW) (Effective January 1, 2023) (a) For the purposes of this section:

(1) "Collaborative Care Model" means the Collaborative Care Model developed at the University of Washington;

(2) "CPT code" means a code number under the Current Procedural Terminology system developed by the American Medical Association; and

(3) "HCPCS code" means a code number under the Healthcare Common Procedure Coding System developed by the federal Centers for Medicare and Medicaid Services.

(b) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes and delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2023, shall provide coverage for health care services that a primary care provider provides to an insured under the Collaborative Care Model. Such services shall include, but need not be limited to, services with a CPT code of 99484, 99492, 99493 or 99494 or HCPCS code of G2214, or any
subsequent corresponding code.

Sec. 58. Subsections (a) and (b) of section 38a-477aa of the general
statutes are repealed and the following is substituted in lieu thereof
(Effective January 1, 2023):

(a) As used in this section:

(1) "Emergency condition" has the same meaning as "emergency
medical condition", as provided in section 38a-591a;

(2) "Emergency services" means, with respect to an emergency
condition, (A) a medical screening examination as required under
Section 1867 of the Social Security Act, as amended from time to time,
that is within the capability of a hospital emergency department,
including ancillary services routinely available to such department to
evaluate such condition, and (B) such further medical examinations and
treatment required under said Section 1867 to stabilize such individual,
that are within the capability of the hospital staff and facilities;

(3) "Health care plan" means an individual or a group health
insurance policy or health benefit plan that provides coverage of the
type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
469;

(4) "Health care provider" means an individual licensed to provide
health care services under chapters 370 to 373, inclusive, chapters 375 to
383b, inclusive, and chapters 384a to 384c, inclusive;

(5) "Health carrier" means an insurance company, health care center,
hospital service corporation, medical service corporation, fraternal
benefit society or other entity that delivers, issues for delivery, renews,
amends or continues a health care plan in this state;

(6) (A) "Surprise bill" means a bill for health care services, other than
emergency services or acute inpatient psychiatric services, received by
an insured for services rendered by an out-of-network health care
provider, where such services were rendered by (i) such out-of-network
provider at an in-network facility, during a service or procedure performed by an in-network provider or during a service or procedure previously approved or authorized by the health carrier and the insured did not knowingly elect to obtain such services from such out-of-network provider, or (ii) a clinical laboratory, as defined in section 19a-30, that is an out-of-network provider, upon the referral of an in-network provider.

(B) "Surprise bill" does not include a bill for health care services received by an insured when an in-network health care provider was available to render such services and the insured knowingly elected to obtain such services from another health care provider who was out-of-network.

(b) (1) No health carrier shall require prior authorization for rendering emergency services or acute inpatient psychiatric services to an insured.

(2) No health carrier shall impose, for emergency services or acute inpatient psychiatric services rendered to an insured by an out-of-network health care provider, a coinsurance, copayment, deductible or other out-of-pocket expense that is greater than the coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed if such emergency services or acute inpatient psychiatric services were rendered by an in-network health care provider.

(3) (A) If emergency services or acute inpatient psychiatric services were rendered to an insured by an out-of-network health care provider, such health care provider may bill the health carrier directly and the health carrier shall reimburse such health care provider the greatest of the following amounts: (i) The amount the insured's health care plan would pay for such services if rendered by an in-network health care provider; (ii) the usual, customary and reasonable rate for such services; or (iii) the amount Medicare would reimburse for such services. As used in this subparagraph, "usual, customary and reasonable rate" means the eightieth percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and
provided in the same geographical area, as reported in a benchmarking database maintained by a nonprofit organization specified by the Insurance Commissioner. Such organization shall not be affiliated with any health carrier.

(B) Nothing in this subdivision shall be construed to prohibit such health carrier and out-of-network health care provider from agreeing to a greater reimbursement amount.

Sec. 59. Subsection (b) of section 20-7f of the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2023):

(b) It shall be an unfair trade practice in violation of chapter 735a for any health care provider to request payment from an enrollee, other than a coinsurance, copayment, deductible or other out-of-pocket expense, for (1) health care services or a facility fee, as defined in section 19a-508c, covered under a health care plan, (2) emergency services, or acute inpatient psychiatric services, covered under a health care plan and rendered by an out-of-network health care provider, or (3) a surprise bill, as defined in section 38a-477aa, as amended by this act.

Sec. 60. Subdivision (3) of subsection (c) of section 38a-193 of the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2023):

(3) No participating provider, or agent, trustee or assignee thereof, may: (A) Maintain any action at law against a subscriber or enrollee to collect sums owed by the health care center; (B) request payment from a subscriber or enrollee for such sums; (C) request payment from a subscriber or enrollee for covered emergency services, or covered acute inpatient psychiatric services, that are provided by an out-of-network provider; or (D) request payment from a subscriber or enrollee for a surprise bill, as defined in section 38a-477aa, as amended by this act. For purposes of this subdivision "request payment" includes, but is not limited to, submitting a bill for services not actually owed or submitting for such services an invoice or other communication detailing the cost.
of the services that is not clearly marked with the phrase "THIS IS NOT A BILL." The contract between a health care center and a participating provider shall inform the participating provider that pursuant to section 20-7f, as amended by this act, it is an unfair trade practice in violation of chapter 735a for any health care provider to request payment from a subscriber or an enrollee, other than a coinsurance, copayment, deductible or other out-of-pocket expense, for covered medical [or] services, emergency services or acute inpatient psychiatric services or facility fees, as defined in section 19a-508c, or surprise bills, or to report to a credit reporting agency an enrollee's failure to pay a bill for such services when a health care center has primary responsibility for payment of such services, fees or bills.

Sec. 61. Subdivision (1) of subsection (c) of section 38a-472f of the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2023):

(c) (1) (A) Each health carrier shall establish and maintain a network that includes a sufficient number and appropriate types of participating providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered benefits will be accessible to all such health carrier's covered persons without unreasonable travel or delay.

(B) Covered persons shall have access to emergency services, as defined in section 38a-477aa, as amended by this act, and acute inpatient psychiatric services twenty-four hours a day, seven days a week.

Sec. 62. Subsection (h) of section 38a-488a of the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2023):

(h) Except in the case of emergency services, acute inpatient psychiatric services or [in the case of] services for which an individual has been referred by a physician or an advanced practice registered nurse affiliated with a health care center, nothing in this section shall be construed to require a health care center to provide benefits under this
Sec. 63. Subsection (h) of section 38a-514 of the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2023):

(h) Except in the case of emergency services, acute inpatient psychiatric services or [in the case of] services for which an individual has been referred by a physician affiliated with a health care center, nothing in this section shall be construed to require a health care center to provide benefits under this section through facilities that are not affiliated with the health care center.

Sec. 64. (Effective from passage) (a) The Insurance Department shall study the rates at which health carriers delivering, issuing for delivery, renewing, amending or continuing individual and group health insurance policies in this state, and third-party administrators licensed under section 38a-720a of the general statutes, reimburse health care providers for covered physical, mental and behavioral health benefits. Such study shall include, but need not be limited to, an assessment of the: (1) Viability of implementing in this state a sliding scale of reimbursement rates; (2) extent to which reimbursement rates for covered mental and behavioral health benefits would need to increase in order to provide a financial incentive to (A) attract additional health care providers to provide covered mental and behavioral health benefits to individuals in this state, and (B) encourage health care providers who provide covered mental and behavioral health benefits to accept new patients in this state; and (3) potential aggregate savings that would accrue to health carriers in this state if insureds were to receive greater access to health care providers who provide covered mental and behavioral health benefits.

(b) Not later than January 1, 2023, the Insurance Department shall, in accordance with section 11-4a of the general statutes, submit a report to the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health disclosing...
the results of the study conducted pursuant to subsection (a) of this section.

Sec. 65. (Effective from passage) (a) As used in this section, "HUSKY Health" has the same meaning as provided in section 17b-290 of the general statutes. The Commissioner of Social Services, in consultation with the Insurance Commissioner, shall conduct a study to determine whether payment parity exists between (1) providers of behavioral and mental health services and providers of other medical services in the private insurance market, (2) such providers within the HUSKY Health program, and (3) HUSKY Health program behavioral and mental health providers and their counterparts in the private insurance market.

(b) The study shall also include, but not be limited to: (1) What rate increases may be necessary to encourage more private providers to offer behavioral and mental health services to HUSKY Health program members, (2) an estimate of the amount such increases would cost the state annually, and (3) potential state savings on other health care costs annually if access to behavioral and mental health providers by HUSKY Health program members is expanded.

(c) Not later than January 1, 2023, the Commissioner of Social Services shall file a report on the study, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to human services, insurance, public health and appropriations and the budgets of state agencies.

Sec. 66. (NEW) (Effective July 1, 2022) (a) As used in this section, (1) "Collaborative Care Model", or "CoCM" means the integrated delivery of behavioral health and primary care services by a primary care team that includes a primary care provider, a behavioral care manager, a psychiatric consultant and a data base used by the behavioral care manager to track patient progress, (2) "CoCM codes" means a billing system developed by the Centers for Medicare and Medicaid Services that provide Medicare rates for services provided in the Collaborative Care Model, and (3) "HUSKY Health" has the same meaning as provided
in section 17b-290 of the general statutes.

(b) To the extent permissible under federal law, the Commissioner of Social Services shall implement a Medicaid reimbursement system that incentivizes collaboration between primary care providers and behavioral and mental health care providers on an integrated care plan for a HUSKY Health program member by separately reimbursing each provider consulting on such patient's care. The commissioner may adopt the Collaborative Care Model to expand access to behavioral and mental health services for HUSKY Health program members and utilize the CoCM codes approved by the Centers for Medicare and Medicaid Services to provide reimbursement to participating providers.

Sec. 67. (Effective July 1, 2022) The following sums are appropriated from the GENERAL FUND for the purposes herein specified for the fiscal year ending June 30, 2023:

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<tr>
<th>T1</th>
<th>GENERAL FUND</th>
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<tr>
<td>T2</td>
<td>DEPARTMENT OF CHILDREN AND FAMILIES (DCF)</td>
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<tr>
<td>T3</td>
<td>Community Kidcare (SID 16141)</td>
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<td>T4</td>
<td>Family Support Services (SID 12304)</td>
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<td>T5</td>
<td>TOTAL - GENERAL FUND - DCF</td>
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Sec. 68. (Effective July 1, 2022) The amount appropriated in section 67 of this act shall be made available to the Department of Children and Families, in its Community Kidcare account, for grants to providers to (1) increase the number of full-time emergency mobile psychiatric services personnel serving children in the state, (2) expand the number of geographic areas in the state in which emergency mobile psychiatric services personnel provide emergency mobile psychiatric services to children, (3) expand the hours of operation during which emergency mobile psychiatric services personnel provide such services to children, and (4) expand the training of personnel providing emergency mobile psychiatric services to children.

Sec. 69. (Effective July 1, 2022) The amount appropriated in section 67 of this act shall be made available to the Department of Children and Families, in its Community Kidcare account, for grants to providers to (1) increase the number of full-time emergency mobile psychiatric services personnel serving children in the state, (2) expand the number of geographic areas in the state in which emergency mobile psychiatric services personnel provide emergency mobile psychiatric services to children, (3) expand the hours of operation during which emergency mobile psychiatric services personnel provide such services to children, and (4) expand the training of personnel providing emergency mobile psychiatric services to children.
Families, in its Family Support Services account, for grants to intensive outpatient services providers, partial hospitalization programs and psychiatric residential treatment facilities in the state to increase the number of providers serving children in need of mental or behavioral health care and to increase the number of beds available to such children through such providers, programs and facilities.

Sec. 70. (Effective July 1, 2022) For the fiscal year ending June 30, 2023, and each fiscal year thereafter, the Department of Children and Families may use any funds available to the department, including, but not limited to, any authorized bond funds, to increase the number of full-time staff of outpatient services providers, partial hospitalization programs and psychiatric residential treatment facilities serving children in need of mental or behavioral health care and the numbers of beds available to such children through such providers, programs and facilities.

Sec. 71. (Effective July 1, 2022) The sum of ____ dollars is appropriated to the Department of Children and Families from the General Fund, for the fiscal year ending June 30, 2023, for hiring new and retaining existing employees who are engaged full-time in mental or behavioral clinical work.

Sec. 72. (Effective July 1, 2022) The sum of ____ dollars is appropriated to the Department of Public Health from the General Fund, for the fiscal year ending June 30, 2023, for increasing the number of medical residencies and fellowships in the practice area of child psychiatry in hospitals in the state.

Sec. 73. (Effective July 1, 2022) The sum of one hundred fifty thousand dollars is appropriated to the Department of Public Health from the General Fund, for the fiscal year ending June 30, 2023, for a grant-in-aid to a children's hospital in the state for the purpose of coordinating a mental and behavioral health training and consultation program, from January 1, 2023, to January 1, 2025, inclusive, which shall be made available to all pediatricians practicing in the state to help them gain the knowledge, experience and confidence necessary to effectively treat
pediatric mental and behavioral health issues.

Sec. 74. (Effective July 1, 2022) For the fiscal year ending June 30, 2023, the Department of Education may expend funds received by the state pursuant to the American Rescue Plan Act of 2021 for the purpose of funding youth membership programs.

Sec. 75. (Effective July 1, 2022) For the fiscal year ending June 30, 2023, to June 30, 2025, the Department of Education may expend funds received by the state pursuant to the American Rescue Plan Act of 2021 for the purpose of administering the grant program that provides grants to local and regional boards of education for the purpose of hiring and retaining additional student mental health specialists pursuant to section 18 of this act.

Sec. 76. (Effective July 1, 2022) For the fiscal year ending June 30, 2023, to June 30, 2025, inclusive, the Department of Education may expend funds received by the state pursuant to the American Rescue Plan Act of 2021 for the purpose of administering the grant program that provides grants to local and regional boards of education for the school-based delivery of mental health services to children and adolescents pursuant to section 19 of this act.

This act shall take effect as follows and shall amend the following sections:

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**Statement of Purpose:**

To improve the availability and provision of mental health, behavioral health and substance use disorder treatment services to children.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]