OLR Bill Analysis

sHB 5001

AN ACT CONCERNING CHILDREN'S MENTAL HEALTH.

TABLE OF CONTENTS:

By January 1, 2023, requires DCF to establish and administer a data repository for emergency mobile psychiatric services personnel to (1) share best practices and (2) along with DCF, collect data on certain patient outcomes when available and appropriate

§ 9 — HOSPITAL PILOT PROGRAM FOR ADOLESCENTS WITH MENTAL OR BEHAVIORAL HEALTH ISSUES

Establishes a pilot program in Waterbury that allows a hospital to administer a partial hospitalization program and an intensive outpatient program for adolescents with mental or behavioral health issues

§ 10 — DCF REGIONAL BEHAVIORAL HEALTH CONSULTATION AND CARE COORDINATION PROGRAM

Expands DCF's regional behavioral health consultation and care coordinating program by, among other things, generally requiring it to provide the pediatric patients served under the program with up to three follow-up telehealth appointments

§§ 11 & 12 — OUT-OF-STATE TELEHEALTH PROVIDERS

Extends PA 21-9's provisions allowing certain out-of-state telehealth providers to provide telehealth services in Connecticut; starting July 1, 2024, permanently authorizes certain out-of-state mental and behavioral health service providers to practice telehealth in Connecticut

§§ 12-13 & 17 — TEMPORARY EXPANSION OF TELEHEALTH SERVICE DELIVERY REQUIREMENTS

Extends PA 21-9's temporary expanded telehealth requirements for the delivery of telehealth services by one year to June 30, 2024

§§ 14-16 — TEMPORARY INSURANCE COVERAGE FOR TELEHEALTH SERVICES

Extends PA 21-9's temporarily expanded insurance coverage requirements and prohibitions for telehealth services by one year to June 30, 2024, and applies the coverage requirements to high deductible health plans to the extent permitted by federal law

§ 18 — OFFICE OF HEALTHCARE ADVOCATE EMPLOYEE

Requires the healthcare advocate to designate an employee to be responsible for Office of Healthcare Advocate services that are specific to minors

§ 19 — STUDENT MENTAL HEALTH SPECIALIST EMPLOYMENT SURVEY

Requires SDE to annually survey boards of education about their employment of student mental health specialists and calculate student-to-specialist ratios for districts and schools

§§ 20 & 85 — GRANT FOR STUDENT MENTAL HEALTH SPECIALIST HIRING AND RETENTION

Requires SDE to administer a grant program for FYs 23-25 to provide funding to boards of education to hire and retain student mental health specialists; allocates an unspecified portion of Coronavirus State Fiscal Recovery Fund dollars to fund the program

§§ 21 & 86 — GRANT FOR SCHOOL-BASED DELIVERY OF STUDENT MENTAL HEALTH SERVICES

Requires SDE to administer a grant program for FYs 23-25 to provide funding to boards of education, youth camps, and other summer program operators for school-based delivery

of student mental health services; allocates an unspecified portion of Coronavirus State Fiscal Recovery Fund dollars to fund the program

§§ 22 & 87 — GRANT FOR COLLEGE AND UNIVERSITY DELIVERY OF STUDENT MENTAL HEALTH SERVICES

Requires OHE to administer a grant program for FYs 23-25 to provide funding to public and private colleges and universities for delivery of student mental health services; allocates an unspecified portion of Coronavirus State Fiscal Recovery Fund dollars to fund the program

§ 23 — DCF DOCUMENTS PROVIDING CHILDREN'S BEHAVIORAL AND MENTAL HEALTH RESOURCES

Sets new requirements for the content and distribution of the existing DCF children's behavioral and mental health resources documents

§ 24 — MENTAL AND BEHAVIORAL HEALTH SCREENING TOOLS

Requires boards of education to post on their websites and distribute to the parent or guardian of a truant student information related to the 2-1-1- Infoline program and other pediatric mental and behavioral health screening services and tools

§ 25 — STUDENT TRUANCY INTERVENTION

Requires each school district to adopt and implement three new policies or procedures related to truant students

§§ 26, 27 & 88 — REGIONAL STUDENT TRAUMA COORDINATORS

Requires each of the state's six regional educational service centers (RESCs) to hire a regional trauma coordinator to, among other things, develop and implement a trauma-informed care training program; requires coordinators to train specialists at the local level to train teachers, administrators, and other staff; allocates an unspecified amount of federal funds for the program; requires progress report and a final report to be submitted to the Children's and Education committees

§ 28 — BEHAVIOR INTERVENTION MEETINGS

Allows classroom teachers to request behavior intervention meetings for students exhibiting disruptive or harmful behavior; requires the safe school climate specialist to hold them

§ 29 — STUDENT TRAUMA ASSESSMENT ADDED TO THE STRATEGIC SCHOOL PROFILE

Adds a needs assessment that identifies resources necessary to address the level of student trauma to the existing list of items included in every school's strategic school profile

§ 30 — STATEWIDE EMERGENCY SERVICE TELECOMMUNICATIONS PLAN

Specifies that the statewide emergency service telecommunications plan must address residents who need mental health, behavioral health, or substance use disorder services

§ 31 — E 9-1-1 COMMISSION

Increases the size of the E 9-1-1 Commission by adding the DPH, DMHAS, and DCF commissioners as members

§ 32 — DESPP COORDINATING ADVISORY BOARD

Expands the DESPP Coordinating Advisory Board by adding the DMHAS commissioner as a member

§§ 33 & 34 — 9-8-8 SUICIDE PREVENTION AND MENTAL HEALTH CRISIS LINE

Establishes a 9-8-8 Suicide Prevention and Mental Health Crisis Lifeline Fund and a process for assessing a monthly fee (up to 75 cents per month per access line) on various telecommunications subscribers for deposit into the fund; sets a corresponding fee on prepaid wireless services

§ 35 — PSAP PROCEDURES FOR 9-1-1 CALLS

Requires DESPP, together with DMHAS, DCF, and DPH, to recommend a plan to incorporate mental and behavioral health and substance use disorder diversion into PSAP procedures for 9-1-1 calls and report it to the legislature by January 1, 2023

§ 36 — CERTIFICATE OF NEED FOR MENTAL HEALTH FACILITIES

(1) Temporarily exempts, from CON requirements, increases in the licensed bed capacity of mental health facilities under certain conditions and (2) requires OHS to report on recommendations for establishing an expedited CON process for mental health facilities

§ 37 — DCF GRANT PROGRAM FOR CERTAIN MENTAL AND BEHAVIORAL HEALTH TREATMENT COSTS

Requires the DMHAS commissioner, by October 1, 2022, to establish a grant program to assist with the costs of obtaining prescribed drugs or treatments and intensive services for children with mental and behavioral health conditions if insurance or Medicaid does not cover them

§ 38 — PEDIATRIC MENTAL HEALTH SCREENING TOOL

By January 1, 2023, requires DPH to develop or procure a screening tool to help pediatricians and emergency room doctors diagnose mental health, behavioral health, or substance use disorders in children

§§ 39-41 — PEER-TO-PEER MENTAL HEALTH SUPPORT PROGRAM

Requires DCF, in collaboration with SDE, to develop a peer-to-peer mental health support program for students in grades 6 - 12; authorizes local and regional boards of education and certain other entities to administer the program in grades 6 – 12, beginning with the 2023-2024 school year

§ 42 — DCF IN-HOME RESPITE CARE SERVICES PROGRAM

Requires the DCF commissioner to establish and administer an in-home respite care services program for children with behavioral health needs; establishes an account within the General Fund to fund the program

§§ 43 & 44 — CONNECTICUT HIGHER EDUCATION SUPPLEMENTAL LOAN AUTHORITY (CHESLA) TECHNICAL CHANGE

Makes a technical change to the definition of "eligible loan"

§ 45 — MENTAL HEALTH CARE PROVIDER LOAN FORGIVENESS PROGRAM

Requires CHESLA, in consultation with DPH, to administer a mental health care provider loan forgiveness program

§ 46 — CHILD PSYCHIATRIST GRANT PROGRAM

Requires DPH to establish a child psychiatrist grant program, providing incentive grants to employers for recruiting, hiring, and retaining child psychiatrists; establishes an advisory board within DPH to advise on the program and approve employers that DPH selects to receive grants

§ 47 — DMHAS ADVERTISING CAMPAIGN

Requires DMHAS, in collaboration with DCF, to (1) plan and implement a statewide advertising campaign on the availability of mental or behavioral health and substance use disorder services in the state and (2) set up a comprehensive website with related information

§ 48 — PEER-TO-PEER SUPPORT PROGRAM FOR CAREGIVERS

Requires DCF, in collaboration with DMHAS, to establish a grant program to create a peer-to-peer support program for parents and caregivers of children with behavioral health needs

§§ 49 & 50 — MENTAL HEALTH WELLNESS EXAMS

Requires certain health insurance policies to cover two mental health wellness examinations per year with no patient cost sharing or prior authorization requirements

§§ 51 & 52 — HEALTH INSURANCE COVERAGE FOR INTENSIVE SERVICES FOR MENTAL CONDITIONS

Requires certain health insurance policies to cover intensive evidence-based, rather than home-based, services to treat children's mental or nervous conditions and expands coverage to include adolescents

§ 53 — SCHOOL-BASED MENTAL HEALTH CLINICS

Requires DCF, DPH, and SDE to develop a plan, potentially including school-based mental health clinics, to promote access to mental health services for children and youth in regions of the state that lack access to school-based health centers

§ 54 — PSYCHOLOGY DOCTORAL STUDENT CLERKSHIP PROGRAM

Requires DPH to establish an incentive program for psychology doctoral students who complete a semester-long clerkship at DCF-licensed or -operated facilities or other agencies DCF deems appropriate

§ 55 — PROTOCOLS FOR EMS TRANSPORT

Requires the Office of Emergency Medical Services to develop protocols for EMS organizations or providers to transport pediatric patients with mental or behavioral health needs by ambulance to DCF-operated urgent care centers

§§ 56 & 57 — HEALTH INSURANCE COVERAGE FOR COLLABORATIVE CARE MODEL SERVICES

Requires certain health insurance policies to cover primary care provider services under a Collaborative Care Model (i.e., the integrated delivery of behavioral health and primary care services by a primary care team)

§§ 58-63 — HEALTH INSURANCE COVERAGE FOR ACUTE INPATIENT PSYCHIATRIC SERVICES

Broadly expands health insurance and emergency access to acute inpatient psychiatric services, including by (1) prohibiting balance billing, higher out-of-network billing, and prior authorization and (2) requiring 24-hour, 7-day per week access to services

§ 58 — PROVIDERS TO NOTIFY HEALTH CARRIERS OF EMERGENCY SERVICES

Requires health care providers providing emergency services to notify an insured's health carrier within three days

§ 64 — OFFICE OF HEALTH STRATEGY REIMBURSEMENT RATE STUDY

Requires the Office of Health Strategy to study the rates at which Connecticut health carriers and third party administrators (TPAs) reimburse health care providers for physical, mental, and behavioral health benefits and report to the Insurance and Real Estate and Public Health committees by January 1, 2023

§ 65 — OHS PAYMENT PARITY STUDY

Requires OHS, in consultation with the insurance commissioner, to study whether payment parity exists between (1) behavioral and mental health services providers and other medical services providers in both HUSKY Health and the private insurance market and (2) behavioral and mental health services providers in HUSKY Health compared to the private market

§ 66 — MEDICAID REIMBURSEMENT SYSTEM

Requires DSS to implement a Medicaid reimbursement system that reimburses providers separately to incentivize collaboration between primary care providers and behavioral health and mental health care providers

§ 67 — YOUTH SERVICE CORPS PROGRAM AND GRANTS

Establishes a Youth Service Corps program administered by DECD to provide grants to certain municipalities to provide paid community-based service learning and academic and workforce development programs to eligible youth and young adults

§§ 68 & 69 — PERMANENT INSURANCE COVERAGE FOR TELEHEALTH SERVICES

Beginning July 1, 2024, permanently requires insurance policies to cover services provided through telehealth to the same extent that they cover them when provided in person by a Connecticut-licensed provider, rather than by any provider

§§ 70-72 — INFORMATION ON CHILDREN'S MENTAL HEALTH AND DOMESTIC VIOLENCE

Sets new distribution requirements for the (1) DCF children's behavioral and mental health resources document and (2) judicial branch's Office of Victim Services (OVS) domestic violence victim resources document

§§ 73 & 74 — VICTIM COMPENSATION PROGRAM EXPANSION

Expands the Victim Compensation Program by extending eligibility to victims of child abuse or neglect substantiated by DCF and victims of certain other crimes against minors

§ 75 — SPECIAL EDUCATION ELIGIBILITY FOR SOCIAL EMOTIONAL DISABILITIES

Extends protections, processes, and services available under special education law to students with social emotional disabilities and their parents and guardians

§§ 76-79 & 81 — DCF APPROPRIATIONS FOR FY 23

Appropriates money from the General Fund to DCF for specified purposes and authorizes the department to use certain funds to provide mental or behavioral services to children

§ 1 — DPH PLAN FOR LICENSURE BY RECIPROCITY OR ENDORSEMENT

Requires DPH, in consultation with DCF, to develop and implement a plan to establish licensure by reciprocity or endorsement for mental or behavioral health care providers licensed elsewhere (with priority given to children's providers)

Existing law provides for licensure by endorsement (also called licensure without examination) for several categories of health care professionals who are licensed in other states. Generally, this applies if, among other conditions, the Department of Public Health (DPH) determines that the other state's licensure standards are substantially similar to, or higher than, Connecticut's.

This bill requires the DPH commissioner, in consultation with the Department of Children and Families (DCF) commissioner, to develop and implement a plan to allow licensure by reciprocity or endorsement for mental or behavioral health care providers licensed or certified (or otherwise entitled to provide these services under a different designation) in other states. The DPH commissioner must prioritize providers licensed or certified (or otherwise entitled) to provide these services to children.

For this licensure to apply:

1. the other state must have requirements for practicing that are substantially similar to, or higher than, the requirements in Connecticut, and

2. the provider must have no disciplinary history or pending unresolved complaints.

When developing and implementing the plan, the DPH commissioner must consider:

1. eliminating barriers to the expedient licensure of these providers, to immediately address the mental health needs of children in the state, and

2. whether the licensure should be limited to telehealth.

Additionally, the bill provides that any interstate licensure compact the state adopts regarding mental or behavioral health care providers would supersede the bill's plan.

By January 1, 2023, DPH must implement and report on the plan to the Public Health and Children's committees, including recommendations for any related legislation.

EFFECTIVE DATE: Upon passage

Background — Related Bills

sHB 5395 (File 173), reported favorably by the Public Health Committee, contains similar provisions requiring DPH to make plans for licensure by reciprocity or endorsement. It also enters Connecticut into two interstate compacts, the Interstate Medical Licensure Compact and the Psychology Interjurisdictional Compact.

sHB 5046 (File 123), reported favorably by the Public Health Committee, enters the state into these two interstate compacts.

sSB 2 (§ 36, File 276), reported favorably by the Children's Committee,

enters the state into the Psychology Interjurisdictional Compact.

§ 2 — EXPEDITED LICENSURE FOR HEALTH CARE PROVIDERS

Expands an existing law on expedited licensure for health care providers licensed in other states by eliminating current provisions limiting it only to state residents or spouses of active duty military members stationed in Connecticut

With certain exceptions, existing law generally requires DPH to issue a health care license or other credential to a person who is licensed in another state and meets specified experience and background requirements (e.g., has practiced under their current license for at least four years and has no disciplinary history). This requirement applies to all DPH-credentialed professions. Current law requires that these applicants be state residents, or the spouse of an active duty service member permanently stationed in Connecticut. The bill removes the residency requirement and instead provides that this law applies at least to active duty military members or their spouses.

The bill similarly eliminates a requirement for DPH to require state residents applying for this licensure to pass an examination, or part of one, required of other applicants. It instead gives DPH the discretion to require an examination for any applicants under these provisions. Under current law, this discretionary authority applies to military spouses only.

By law, (1) applicants for expedited licensure must pay any credentialing fees required of other applicants and (2) DPH may deny a credential if the commissioner finds it to be in the state's best interest.

EFFECTIVE DATE: October 1, 2022

§ 3 — SOCIAL WORK LICENSURE EXAMINATION

Requires the DPH commissioner to notify clinical and master social worker license applicants that they may use a dictionary while taking the licensure examination

The bill requires the DPH commissioner to notify every clinical and master social worker licensure applicant that he or she may use a dictionary when taking the licensure examination.

EFFECTIVE DATE: July 1, 2022

§ 4 — MASTER SOCIAL WORK LICENSE TEMPORARY PERMITS

Extends, until June 30, 2024, the duration of temporary master social worker permits, from 120 days to one year after attaining a master's degree and specifies that they are not void solely because the applicant fails the examination

The bill extends, until June 30, 2024, the duration of temporary permits for master social workers, from 120 days to one year after attaining a master's degree. The bill specifies that a temporary permit is not void only because the applicant fails the examination.

Starting June 30, 2024, the bill reduces the duration of the temporary permits to 120 days after they are issued and makes them void if the applicant fails the licensure examination.

By law, a temporary permit allows licensure applicants who have a master's degree from a social work program, but have not yet taken the licensure exam, to practice under professional supervision.

EFFECTIVE DATE: Upon passage

§ 5 — MENTAL HEALTH CARE PROVIDER EXAMINATION PREPARATION GRANT PROGRAM

Requires the DPH commissioner to establish a Mental Health Care Provider Examination Preparation Grant Program to provide grants to social worker licensure applicants to cover the costs of tutoring, interpreter services (if applicable), and certain examination preparation courses

The bill requires the DPH commissioner to establish a Mental Health Care Provider Examination Preparation Grant Program to provide grants to social workers and marital and family therapists who are applying for licensure as a clinical or master social worker. The grants must be used to cover the costs of:

1. tutoring;

2. interpreter services for applicants who are English language learners; and

3. examination preparation courses for the Association of Social Work Board's master's level or clinical level examinations, or any other examination the commissioner prescribes.

The bill also requires the commissioner to establish guidelines for the grant program's administration.

EFFECTIVE DATE: October 1, 2022

§ 6 — MENTAL AND BEHAVIORAL HEALTH CARE LICENSURE APPLICANT SCHOLARSHIP PROGRAM

Requires DPH, within available appropriations, to establish a scholarship program for licensure applicants in professions that serve the mental or behavioral needs of the state's children

The bill requires the DPH commissioner, within available appropriations and in consultation with the DCF commissioner, to establish a scholarship program for licensure applicants in professions that serve children's mental and behavioral health needs in Connecticut. It allows the department to accept private donations for the program.

Under the bill, the program must provide need-based scholarships to DPH licensure applicants in professions that serve children's mental and behavioral health needs. The scholarship amount cannot exceed the combined cost of application and licensure fees.

The bill requires the DPH commissioner to develop scholarship eligibility requirements and give priority to applicants (1) who are members of a racial or ethnic minority, (2) for whom English is a second language, (3) who identify as gay, lesbian, bisexual, transgender, or queer, or (4) who have a disability.

Under the bill, unexpended funds do not lapse at the end of the fiscal year and must be available to spend in the following fiscal year. It allows the DPH commissioner to use up to 5% of the funds appropriated for the program for its administration, promotion, recruitment, and retention activities.

Starting by January 1, 2023, the bill requires the DPH commissioner to annually report to the Public Health Committee on the program, including (1) the number of scholarship recipients and their demographics; (2) where available, the demographics of the people served by the scholarship recipients in their professional capacities; and (3) a detailed description of how DPH uses the money allocated to the

program for its administration.

EFFECTIVE DATE: Upon passage

§ 7 — CHILDREN'S MENTAL HEALTH ADVISORY BOARD

Changes the composition of the Children's Mental, Emotional, and Behavioral Health Plan Implementation Advisory Board by adding 11 new members and specifying the required credentials of the DCF commissioner's appointees

The bill changes the composition of the Children's Mental, Emotional, and Behavioral Health Plan Implementation Advisory Board by (1) increasing its total membership from 34 to 45 and (2) specifying the required professional background of each of the DCF commissioner's appointees.

It adds the following 11 new members:

1. the correction and labor commissioners, or their designees;
2. the Office of Policy Management (OPM) secretary, or his designee;
3. a representative of the governor's office;
4. one representative of commercial health insurance carriers;
5. one representative of the Commission on Racial Equity in Public Health;
6. one representative of the Commission on the Disparate Impact of COVID-19;
7. one representative of the task force studying mental health service provider networks (as required under PA 21-125);
8. one representative of the task force studying children's needs (as required under PA 21-46); and
9. two more appointees by the DCF commissioner.

With respect to the DCF commissioner's appointees, it increases, from 4 to 6, the number of mental, emotional, or behavioral health care

services providers she must appoint to the board and specifies their required professional background as follows: a licensed psychiatrist, marital and family therapist, psychologist, clinical social worker, professional counselor, and an advanced practice registered nurse. Under the bill, at least one of these appointees must be a mental, emotional or behavioral health care provider to children involved in the juvenile justice system.

By law, the board must advise specified individuals and entities on executing DCF's comprehensive behavioral health plan, among other things.

EFFECTIVE DATE: July 1, 2022

§ 8 — DCF DATA REPOSITORY – EMERGENCY MOBILE PSYCHIATRIC SERVICES

By January 1, 2023, requires DCF to establish and administer a data repository for emergency mobile psychiatric services personnel to (1) share best practices and (2) along with DCF, collect data on certain patient outcomes when available and appropriate

The bill requires DCF, by January 1, 2023, and for internal quality improvement purposes, to establish and administer a data repository for:

1. emergency mobile psychiatric services personnel to share best practices and experiences while providing these services in the field; and

2. these personnel and DCF, when available and appropriate, to collect data on patient outcomes for those who received emergency mobile psychiatric services.

It requires DCF to deidentify and disaggregate the data.

EFFECTIVE DATE: July 1, 2022

§ 9 — HOSPITAL PILOT PROGRAM FOR ADOLESCENTS WITH MENTAL OR BEHAVIORAL HEALTH ISSUES

Establishes a pilot program in Waterbury that allows a hospital to administer a partial hospitalization program and an intensive outpatient program for adolescents with mental or behavioral health issues

The bill establishes a pilot program in Waterbury, administered by DPH, that allows a hospital to administer a partial hospitalization program and an intensive outpatient program for adolescents with mental or behavioral health issues. Under the bill, a "partial hospitalization program" is a structured program of outpatient psychiatric services as an alternative to inpatient psychiatric care.

Annually, beginning by January 1, 2024, the bill requires the DPH commissioner, in consultation with the DCF commissioner, to report to the Public Health and Children's committees on the program's implementation and effectiveness, including legislative recommendations on implementing the program statewide.

EFFECTIVE DATE: October 1, 2022

§ 10 — DCF REGIONAL BEHAVIORAL HEALTH CONSULTATION AND CARE COORDINATION PROGRAM

Expands DCF's regional behavioral health consultation and care coordinating program by, among other things, generally requiring it to provide the pediatric patients served under the program with up to three follow-up telehealth appointments

Existing law requires DCF's regional behavioral health consultation and care coordination program to provide certain services to primary care providers who serve children. Specifically, the program must give the providers (1) timely access to a consultation team, including a child psychiatrist, social worker, and care coordinator; (2) patient care coordination and transitional services for behavioral health care; and (3) training and education on patient access to behavioral health services.

The bill expands this program by also requiring it to provide (1) specified services to the primary care providers' pediatric patients and (2) patient care coordination and transitional services for mental health care to the primary care providers. With respect to the pediatric patients, the program must provide up to three follow-up telehealth appointments with a mental health care provider after the primary care provider has used the program on the patient's behalf if the provider determines it to be medically necessary.

The bill also authorizes the providers to refer the patients to a care

coordinator who contracts with DCF, but is not participating in the program, to help the patients get behavioral health care from a non-participating mental or behavioral health care provider.

Under the bill, DCF must request reimbursement from a health carrier for services provided under the program before paying for the services with appropriated funds.

The bill also deletes obsolete language.

EFFECTIVE DATE: Upon passage

§§ 11 & 12 — OUT-OF-STATE TELEHEALTH PROVIDERS

Extends PA 21-9's provisions allowing certain out-of-state telehealth providers to provide telehealth services in Connecticut; starting July 1, 2024, permanently authorizes certain out-of-state mental and behavioral health service providers to practice telehealth in Connecticut

Temporary Out-of-State Providers

PA 21-9 temporarily allows out-of-state authorized telehealth providers (see *Background*) to practice telehealth in Connecticut until June 30, 2023. The bill extends this date by one year until June 30, 2024. As under PA 21-9, the bill requires these providers to:

1. be appropriately licensed, certified, or registered in another U.S. state or territory, or the District of Columbia;

2. be authorized to practice telehealth under any relevant order issued by the DPH commissioner; and

3. have professional liability insurance or other indemnity against professional malpractice liability in an amount at least equal to that required for Connecticut health providers.

The bill also extends until June 30, 2024, the requirement under PA 21-9 that Connecticut entities, providers, or institutions who contract with out-of-state telehealth providers:

1. verify the provider's credentials to ensure the provider is certified, licensed, or registered and in good standing in his or her home jurisdiction and

2. confirm that the telehealth provider has professional liability insurance or other indemnity against professional malpractice liability in an amount at least equal to that required for Connecticut health providers. (The bill does not extend this requirement to mental and behavioral health providers below.)

Mental and Behavioral Health Providers

Starting July 1, 2024, the bill permanently authorizes out-of-state mental or behavioral health service providers to practice telehealth in Connecticut if the provider:

1. is appropriately licensed, certified, or registered in another U.S. state or territory, or the District of Columbia, as a physician, naturopath, registered nurse, advanced practice registered nurse, physician assistant, psychologist, marital and family therapist, clinical or master social worker, alcohol and drug counselor, professional counselor, dietician-nutritionist, nurse-midwife, behavior analyst, or music or art therapist;

2. is providing mental or behavioral health services within his or her professional scope of practice and professional standards of care; and

3. maintains professional liability insurance or other indemnity against professional malpractice liability in an amount equal to or greater than what is required in Connecticut for these providers.

Background — Authorized Telehealth Providers

Under PA 21-9 and the bill, authorized telehealth providers until June 30, 2024, include: advanced practice registered nurses, alcohol and drug counselors, art therapists, athletic trainers, audiologists, behavior analysts, certified dietician-nutritionists, chiropractors, clinical and master social workers, dentists, genetic counselors, marital and family therapists, music therapists, naturopaths, occupational or physical therapists and therapist assistants, optometrists, paramedics, pharmacists, physicians, physician assistants, podiatrists, professional

counselors, psychologists, registered nurses, respiratory care practitioners, and speech and language pathologists.

EFFECTIVE DATE: Upon passage

§§ 12-13 & 17 — TEMPORARY EXPANSION OF TELEHEALTH SERVICE DELIVERY REQUIREMENTS

Extends PA 21-9's temporary expanded telehealth requirements for the delivery of telehealth services by one year to June 30, 2024

Existing law generally sets requirements for the provision of telehealth services by authorized providers. PA 21-9 temporarily replaces these requirements with similar, but more expansive, requirements for authorized providers who are (1) in-network providers for fully insured health plans or (2) Connecticut Medical Assistance Program ("CMAP," i.e., Medicaid and HUSKY B) providers until June 30, 2023. This bill extends the more expansive requirements described below by one year until June 30, 2024.

The bill also extends by one year until June 30, 2024, a provision in PA 21-9 that permits physicians and advanced practice registered nurses to certify a qualifying patient's use of medical marijuana and provide follow-up care using telehealth if they comply with other statutory certification and recordkeeping requirements. As under current law, they may do so despite existing laws, regulations, policies, or procedures on medical marijuana certifications.

EFFECTIVE DATE: Upon passage

Audio-Only Telephone

The bill allows in-network and CMAP telehealth providers to provide telehealth services via audio-only telephone until June 30, 2024. Under existing law, "telehealth" excludes fax, texting, and email. It includes:

1. interaction between a patient at an originating site and the telehealth provider at a distant site and

2. synchronous (real-time) interactions, asynchronous store and forward transfers (transmitting medical information from the

patient to the telehealth provider for review at a later time), or remote patient monitoring.

Service Provision

By law, a telehealth provider can provide telehealth services to a patient only when the provider has met certain requirements, such as (1) having access to, or knowledge of, the patient's medical history and health record and (2) conforming to his or her professional standard of care expected for in-person care appropriate for the patient's age and presenting condition.

The bill requires, until June 30, 2024, that the provider also determine whether the (1) patient has health coverage that is fully insured, not fully insured, or provided through CMAP and (2) coverage includes telehealth services. It also allows telehealth providers to provide telehealth services from any location, regardless of any state licensing standards and subject to compliance with applicable federal requirements.

Initial Telehealth Interactions

Existing law requires a provider, at the first telehealth interaction with a patient, to document in the patient's medical record that he or she obtained the patient's consent after giving information about telehealth methods and limitations. Until June 30, 2024, the bill requires this to include information on the limited duration of the bill's provisions. A patient's revocation of consent must also be documented in their medical record.

Use of Additional Communication Technologies

The bill modifies the requirement that telehealth services and health records comply with the Health Insurance Portability and Accountability Act (HIPAA) by allowing telehealth providers to use more information and communication technologies in accordance with HIPAA requirements for remote communication as directed by the federal Department of Health and Human Services' Office of Civil Rights (e.g., certain third-party video communication applications, such as Apple FaceTime, Skype, or Facebook Messenger). The bill allows the

use of these additional information and communication technologies until June 30, 2024.

Payment for Uninsured and Underinsured Patients

The bill requires a telehealth provider to determine whether the patient has health coverage for any such services provided. Under the bill, the provider must accept the following as payment in full for telehealth services until June 30, 2024:

1. for patients who do not have health insurance coverage for telehealth services, an amount equal to the Medicare reimbursement rate for telehealth services or

2. for patients with health insurance coverage, the amount the carrier reimburses for telehealth services and any cost sharing (e.g., copay, coinsurance, deductible) or other out-of-pocket expense imposed by the health plan.

Under the bill, a telehealth provider who determines that a patient is unable to pay for telehealth services must offer the patient financial assistance to the extent required under federal or state law.

DPH Regulatory Requirements

Regardless of existing law, the act authorizes the DPH commissioner to waive, modify, or suspend regulatory requirements adopted by DPH or state licensing boards and commissions regarding health care professions, health care facilities, emergency medical services, and other specified topics. Until June 30, 2024, she may do this as she deems necessary to reduce the spread of COVID-19 and protect the public health.

§§ 14-16 — TEMPORARY INSURANCE COVERAGE FOR TELEHEALTH SERVICES

Extends PA 21-9's temporarily expanded insurance coverage requirements and prohibitions for telehealth services by one year to June 30, 2024, and applies the coverage requirements to high deductible health plans to the extent permitted by federal law

Extension of Expanded Coverage Requirements

Existing law generally sets requirements and restrictions for health

insurance coverage of services provided through telehealth. PA 21-9 temporarily replaces these requirements with similar but more expansive requirements for telehealth coverage until June 30, 2023. This bill extends the more expansive requirements until June 30, 2024.

Coverage Required. As with existing law, the bill requires certain commercial health insurance policies to cover medical advice, diagnosis, care, or treatment provided through telehealth to the extent that they cover those services when provided in person. It generally subjects telehealth coverage to the same terms and conditions that apply to other benefits under a health policy. Under the bill and existing law, insurers, HMOs, and related entities may conduct utilization reviews for telehealth services in the same way they do for in-person services, including using the same clinical review criteria.

Prohibitions. Under the bill, health insurance policies cannot exclude coverage (1) just because a service is provided through telehealth, as long as telehealth is appropriate, or (2) for a telehealth platform that a telehealth provider selects.

Also, telehealth providers who receive reimbursement for providing a telehealth service may not seek any payment from the insured patient except for cost sharing (e.g., copay, coinsurance, deductible) and must accept the amount as payment in full.

Lastly, the bill prohibits health carriers (e.g., insurers and HMOs), until June 30, 2024, from reducing the amount of reimbursement they pay to telehealth providers for covered services appropriately provided through telehealth instead of in person.

Applicability

The bill applies to fully insured individual and group health insurance policies in effect any time from May 10, 2021, until June 30, 2024, that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. (Because of the federal Employee Retirement Income Security Act (ERISA), state insurance

benefit mandates do not apply to self-insured benefit plans.)

The bill also applies these requirements to high deductible health plans (HDHPs) to the maximum extent permitted by federal law. If the HDHP is used to establish a health savings account or similar account, the bill applies to the maximum extent permitted by federal law and that does not affect the account's tax preferred status.

EFFECTIVE DATE: Upon passage

§ 18 — OFFICE OF HEALTHCARE ADVOCATE EMPLOYEE

Requires the healthcare advocate to designate an employee to be responsible for Office of Healthcare Advocate services that are specific to minors

By October 1, 2022, the bill requires the state's healthcare advocate to designate an Office of Healthcare Advocate employee to (1) perform the office's duties for minors and (2) coordinate statewide efforts to ensure minors have coverage for, and access to, services for behavioral and mental health conditions and substance use disorders.

EFFECTIVE DATE: July 1, 2022

§ 19 — STUDENT MENTAL HEALTH SPECIALIST EMPLOYMENT SURVEY

Requires SDE to annually survey boards of education about their employment of student mental health specialists and calculate student-to-specialist ratios for districts and schools

Beginning by October 1, 2022, the bill requires the education commissioner to develop and distribute an annual survey to each local and regional board of education, within available appropriations, about their employment of student mental health specialists. Under the bill, these specialists are school social workers, school psychologists, trauma specialists, behavior technicians, board-certified behavior analysts, school counselors, licensed professional counselors, and licensed marriage and family therapists.

The bill requires the survey to include at least:

1. the total number of student mental health specialists for the district as a whole and for each individual school in the district;

2. a disaggregation of the total number of each school social worker, school psychologist, trauma specialist, behavior technician, board-certified behavior analyst, school counselor, licensed professional counselor, and licensed marriage and family therapist in the district and in each school in the district, including whether any of them are assigned just to one school or to multiple schools;

3. the geographic area covered by any student mental health specialist who provides services to more than one board of education; and

4. an estimate of the annual number of students who have received direct services from each individual student mental health specialist during the five years prior to the survey's completion.

Beginning in the 2022-23 school year, each board of education must complete the survey and submit it to the commissioner when and how she determines. After receiving a completed survey, the commissioner must annually calculate the student-to-specialist ratio for the board and for each school under its jurisdiction. The commissioner must report the survey results and ratios to the Education and Children's committees by January 1, 2023, and each year after.

EFFECTIVE DATE: Upon passage

§§ 20 & 85 — GRANT FOR STUDENT MENTAL HEALTH SPECIALIST HIRING AND RETENTION

Requires SDE to administer a grant program for FYs 23-25 to provide funding to boards of education to hire and retain student mental health specialists; allocates an unspecified portion of Coronavirus State Fiscal Recovery Fund dollars to fund the program

The bill requires the State Department of Education (SDE) to administer a grant program to provide grants in FYs 23-25 to local and regional boards of education for hiring and retaining student mental health specialists.

The bill allocates an unspecified amount of the funds the state received under the Coronavirus State Fiscal Recovery Fund established by the American Rescue Plan Act of 2021 (ARPA) (P.L. 117-2) to SDE for

FYs 23-25 to administer the program. It also allows SDE to accept the following funding sources to support the program's administration: private source or state agency funds and gifts, grants, and donations, including in-kind donations.

Application Process

Under the bill, boards must file grant applications with the education commissioner when and how she determines. As part of its application, a board must submit a copy of its completed student mental health specialist employment survey (see § 19 above) and a plan for grant fund spending. This plan must include at least:

1. the number of (a) additional specialists to be hired and (b) specialists being retained who were previously hired with the assistance of these grant funds,

2. whether these specialists will be conducting student assessments or providing student services based on the assessment's results, and

3. the type of services that the specialists will provide.

Award Process

The bill gives the commissioner the authority to determine (1) whether to award grants to applicant boards and (2) the amount of a recipient's initial grant award based on its submitted plan. But it requires the commissioner to prioritize school districts with a large student-to-specialist ratio or a high volume of students using mental health services.

Additionally, the bill establishes the following grant amounts for the commissioner to award for the duration of the grant program: (1) for FY 23, a commissioner-determined amount; (2) for FY 24, the same amount awarded in FY 23; and (3) for FY 25, 70% of the amount awarded in FY 24.

Program Tracking

Under the bill, grant recipients must file annual expenditure reports

with SDE and refund to the department (1) any unspent grant amount at the end of the fiscal year when it was awarded and (2) any unspent grant amount under the plan submitted in the grant application.

The bill requires SDE to annually track and calculate each recipient's grant program utilization rate and the grant program's return on investment. The department must calculate the utilization rate using, at a minimum, the number of students the recipient served and hours of service it provided using grant program funds. SDE must calculate the program's return on investment using the utilization rate calculations and expenditure reports filed by the grant recipients.

Reports to the Legislature

Beginning by January 1, 2024, and for the two subsequent years, the bill requires the education commissioner to report to the Education and Children's committees on each grant recipient's utilization rate and the grant program's return on investment.

Additionally, the bill requires the commissioner to develop recommendations on the following topics and submit them to the same legislative committees by January 1, 2026: (1) whether this grant program should be extended and funded for FY 26 and beyond and (2) the grant award amount under the program.

EFFECTIVE DATE: July 1, 2022

§§ 21 & 86 — GRANT FOR SCHOOL-BASED DELIVERY OF STUDENT MENTAL HEALTH SERVICES

Requires SDE to administer a grant program for FYs 23-25 to provide funding to boards of education, youth camps, and other summer program operators for school-based delivery of student mental health services; allocates an unspecified portion of Coronavirus State Fiscal Recovery Fund dollars to fund the program

The bill requires SDE to administer a grant program to provide grants in FYs 23-25 to boards of education, youth camps, and other summer program operators for school-based delivery of student mental health services.

The bill allocates an unspecified amount of the funds the state received under the Coronavirus State Fiscal Recovery Fund established

by the American Rescue Plan Act of 2021 (ARPA) (P.L. 117-2) to SDE for FYs 23-25 to administer the program. It also allows SDE to accept the following funding sources to support the program's administration: private source or state agency funds and gifts, grants, and donations, including in-kind donations.

Application Process

Under the bill, boards must file grant applications with the education commissioner when and how she determines. As part of its application, a board must submit a plan for grant fund spending.

Award Process

The bill gives the commissioner the authority to determine (1) whether to award grants to applicant boards and (2) the amount of a recipient's initial grant award based on its submitted plan. It establishes the following grant amounts for the commissioner to award for the duration of the grant program: (1) for FY 23, a commissioner-determined amount; (2) for FY 24, the same amount awarded in FY 23; and (3) for FY 25, 70% of the amount awarded in FY 24.

Program Tracking

Under the bill, grant recipients must file annual expenditure reports with SDE and refund to the department (1) any unspent grant amount at the end of the fiscal year when it was awarded and (2) any unspent grant amount under the plan submitted in the grant application.

The bill requires each grant recipient to work with the department to develop metrics to annually track and calculate the grant program's utilization rate, which will measure the program's success. Grant recipients must submit these metrics and the utilization rate to SDE each year.

Reports to the Legislature

Beginning by January 1, 2024, and for the next two years, the bill requires the education commissioner to report to the Education and Children's committees on each grant recipient's utilization rate.

Additionally, the bill requires the commissioner to develop recommendations on the following topics and submit them to the same legislative committees by January 1, 2026: (1) whether this grant program should be extended and funded for FY 26 and beyond and (2) the grant award amount under the program.

EFFECTIVE DATE: Upon passage, but the ARPA fund allocation takes effect on July 1, 2022.

§§ 22 & 87 — GRANT FOR COLLEGE AND UNIVERSITY DELIVERY OF STUDENT MENTAL HEALTH SERVICES

Requires OHE to administer a grant program for FYs 23-25 to provide funding to public and private colleges and universities for delivery of student mental health services; allocates an unspecified portion of Coronavirus State Fiscal Recovery Fund dollars to fund the program

The bill requires the Office of Higher Education (OHE) to administer a grant program to provide grants in FYs 23-25 to public and private higher education institutions to deliver student mental health services on campus.

The bill allocates an unspecified amount of the funds the state received under the Coronavirus State Fiscal Recovery Fund established by the American Rescue Plan Act of 2021 (ARPA) (P.L. 117-2) to OHE for FYs 23-25 to administer the program. It also allows OHE to accept the following funding sources to support the program's administration: private source or state agency funds and gifts, grants, and donations, including in-kind donations.

Application Process

Under the bill, boards must file grant applications with the OHE executive director when and how he determines. As part of its application, an institution must submit a plan for grant fund spending.

Award Process

The bill gives OHE's executive director the authority to determine (1) whether to award grants to applicants and (2) the amount of a recipient's initial grant award based on its submitted plan. It establishes the following grant amounts for the executive director to award for the

duration of the grant program: (1) for FY 23, a commissioner-determined amount; (2) for FY 24, the same amount awarded in FY 23; and (3) for FY 25, 70% of the amount awarded in FY 24. (Presumably, the OHE executive director, not a commissioner, is calculating the FY 23 amount.)

Program Tracking

Under the bill, grant recipients must file annual expenditure reports with the OHE executive director and refund to the office (1) any unspent grant amount at the end of the fiscal year when it was awarded and (2) any unspent grant amount under the plan submitted in the grant application.

The bill requires each grant recipient to work with the office to develop metrics to annually track and calculate the grant program's utilization rate, which will measure the program's success. Grant recipients must submit these metrics and the utilization rate to OHE each year.

Reports to the Legislature

Beginning by January 1, 2024, and for the next two years, the bill requires the OHE executive director to report to the Higher Education and Employment Advancement Committee on each grant recipient's utilization rate.

Additionally, the bill requires the executive director to develop recommendations on the following topics and submit them to the same committee by January 1, 2026: (1) whether this grant program should be extended and funded for FY 26 and beyond and (2) the grant award amount under the program.

EFFECTIVE DATE: Upon passage, but the ARPA fund allocation takes effect on July 1, 2022.

§ 23 — DCF DOCUMENTS PROVIDING CHILDREN'S BEHAVIORAL AND MENTAL HEALTH RESOURCES

Sets new requirements for the content and distribution of the existing DCF children's behavioral and mental health resources documents

Existing law requires DCF, in consultation with certain entities, to develop a document for each mental health region describing the behavioral and mental health evaluation and treatment resources available to children (see *Background*). The bill sets new requirements for the content and distribution of these documents.

Beginning July 1, 2022, the bill requires the documents to:

1. include information on the existence and availability of the 2-1-1 Infoline program and other pediatric mental and behavioral health screening tools; and

2. be provided in multiple languages, including English, Polish, Portuguese, and Spanish.

The bill also requires the Behavioral Health Partnership Oversight Council (BHPOC) to distribute the documents electronically to the Department of Emergency Services and Public Protection (DESPP), each municipal police department, and each ambulance company and organization that offers transportation or treatment services to patients under emergency conditions.

EFFECTIVE DATE: July 1, 2022

Background — Children's Behavioral and Mental Health Resources Documents

By law, DCF must develop the children's behavioral and mental health resources documents in consultation with the BHPOC, the Mental Health and Addiction Services and Public Health Departments, and DCF's Youth Suicide Advisory Board. BHPOC is required to (1) distribute the documents electronically to each licensed hospital with an emergency department and to each local and regional board of education and (2) make them available on the council's website.

Background — Related Bill

sHB 5154, (File No. 60), favorably reported by the Children's Committee, contains identical provisions requiring (1) the document to be provided in multiple languages, and (2) BHPOC to distribute the

document electronically to certain emergency departments, companies, and organizations.

§ 24 — MENTAL AND BEHAVIORAL HEALTH SCREENING TOOLS

Requires boards of education to post on their websites and distribute to the parent or guardian of a truant student information related to the 2-1-1- Infoline program and other pediatric mental and behavioral health screening services and tools

By law, each local and regional board of education must make available on its website the DCF document on behavioral and mental health evaluation and treatment resources available to children in the mental health region where the board is located. Existing law also requires each board of education to distribute the resources document described above (1) to any student taking a course in health and safety, and (2) at least semiannually, in September and May, to the parents and guardians of each student in the school district.

Under the bill, beginning every year with the 2022-23 school year, each board of education must also:

1. post on its website information on the 2-1-1 Infoline program and other pediatric mental and behavioral health screening services and tools, and

2. distribute the document, including the new information required under the bill, to the parent or guardian of a student who is truant under law.

EFFECTIVE DATE: July 1, 2022

§ 25 — STUDENT TRUANCY INTERVENTION

Requires each school district to adopt and implement three new policies or procedures related to truant students

Existing law requires each school district to adopt and implement policies or procedures related to truant students and specifies various requirements that the policies and procedures must include.

The bill adds three new requirements. First, it requires school districts to provide notice to a truant child's parent or guardian of the availability of the 2-1-1 Infoline program and other pediatric mental and behavioral

health screening services and tools.

The bill also requires that, beginning July 1, 2023, an appropriate student mental health specialist (as defined in § 19) conduct an evaluation of each child who is a truant to determine if more behavioral health interventions are necessary. It requires that the evaluation include, to the extent possible, an evaluation of the psychological, mental, emotional, economic, and physical needs of the child and the child's family.

Lastly, the bill requires each school district, by September 1, 2023, to adopt and implement an SDE-developed truancy intervention model that accounts for mental and behavioral health. (However, neither the bill nor existing law appear to require SDE to develop this model.)

EFFECTIVE DATE: July 1, 2022

§§ 26, 27 & 88 — REGIONAL STUDENT TRAUMA COORDINATORS

Requires each of the state's six regional educational service centers (RESCs) to hire a regional trauma coordinator to, among other things, develop and implement a trauma-informed care training program; requires coordinators to train specialists at the local level to train teachers, administrators, and other staff; allocates an unspecified amount of federal funds for the program; requires progress report and a final report to be submitted to the Children's and Education committees

The bill requires, for FYs 23 and 24, each regional educational service center (RESC) to hire an individual to serve as the RESC's regional trauma coordinator (i.e., "coordinator"). The bill makes each coordinator responsible for, among other duties, developing and implementing a trauma-informed care training program as required under the bill and providing technical assistance in implementing the program with the boards of education that are the RESC's member boards.

Specifically, the bill requires the RESC coordinators to jointly develop and implement the training program with a training model enabling student mental health specialists to do trauma-informed care training for all teachers, administrators, and other school staff and coaches when they complete the program. In developing the training program, the regional trauma coordinators may collaborate with nonprofit

organizations in the state that focus on child health and development and trauma-informed care for children.

The bill requires the coordinators to offer this training at no cost to student mental health specialists or the RESC member boards of education that employ the specialists. Any student mental health specialist who has participated in the trauma-informed care program must be the one providing this training to teachers, administrators, and other school staff and coaches under the bill.

The bill permits a board of education to enter into an agreement with the RESC trauma coordinator to provide the trauma-informed care training program as part of the school district's in-service training program.

EFFECTIVE DATE: July 1, 2022, except the funding provision is effective upon passage.

Funding

The bill allocates an unspecified amount of federal American Rescue Plan Act of 2021 (P.L. 117-2) funds designated to the state and SDE, for FYs 23 and 24, for each RESC to hire a coordinator as the bill requires and to implement the bill's trauma-informed care training program.

Progress Report and Final Report

The bill requires each coordinator to (1) develop a progress report and a final report on the training program's implementation, (2) submit the progress report to the Children and Education committees by January 1, 2024, and (3) submit the final report to the same committees by January 1, 2025.

Under the bill, the progress report must cover the training program's implementation in FY 23, including an analysis of its effectiveness and results. The final report must cover the program's implementation in FYs 23 and 24 and include (1) an analysis of the program's effectiveness and results and (2) recommendations on whether it should be extended and funded for FYs 25 and 26.

§ 28 — BEHAVIOR INTERVENTION MEETINGS

Allows classroom teachers to request behavior intervention meetings for students exhibiting disruptive or harmful behavior; requires the safe school climate specialist to hold them

Beginning in the 2022-23 school year, the bill allows any classroom teacher to request that the school's safe school climate specialist convene a behavior intervention meeting for any student whose behavior has caused (1) a serious disruption to other students' instruction or (2) self-harm or physical harm to the teacher, another student, or staff in the teacher's classroom. By law, the school principal or his or her designee serves as the safe school climate specialist and is tasked with preventing, identifying, and responding to acts of bullying consistent with the district's safe school climate plan (CGS § 10-222k(b)).

The safe school climate specialist must hold the meeting, and its participants must identify resources and supports to address the social, emotional, and instructional needs of the student of concern. (The bill does not specify who must participate in the meeting.)

EFFECTIVE DATE: July 1, 2022

§ 29 — STUDENT TRAUMA ASSESSMENT ADDED TO THE STRATEGIC SCHOOL PROFILE

Adds a needs assessment that identifies resources necessary to address the level of student trauma to the existing list of items included in every school's strategic school profile

Existing law requires each school district superintendent to annually submit to SDE a strategic school profile that, among other things, provides information on measures of student needs. The bill requires boards to include, as part of this category, a needs assessment that identifies resources necessary to address the level of student trauma impacting students and staff in each school. (Under current law "student needs" are not further defined.)

The strategic school profile includes data on student performance, school resources, special education, and other items. The law requires each superintendent to submit data for the superintendent's entire district and each school individually for the strategic school profile.

EFFECTIVE DATE: July 1, 2022

§ 30 — STATEWIDE EMERGENCY SERVICE TELECOMMUNICATIONS PLAN

Specifies that the statewide emergency service telecommunications plan must address residents who need mental health, behavioral health, or substance use disorder services

By law, the Department of Emergency Services and Public Protection's (DESPP's) Division of State-Wide Emergency Telecommunications, in cooperation with the Public Utilities Regulatory Authority, must develop a statewide emergency service telecommunications plan identifying emergency police, fire, and medical service telecommunications systems needed to provide coordinated emergency service telecommunications to all state residents, including people with physical disabilities. The bill specifies that the plan must also address residents who need mental health, behavioral health, or substance use disorder services.

EFFECTIVE DATE: October 1, 2022

§ 31 — E 9-1-1 COMMISSION

Increases the size of the E 9-1-1 Commission by adding the DPH, DMHAS, and DCF commissioners as members

The bill increases the membership of the E 9-1-1 Commission from 13 to 16 by adding the DPH, Department of Mental Health and Addiction Services (DMHAS), and DCF commissioners, or their respective designees, as members. All of the members, including the three the bill adds, are appointed by the governor for three-year terms and serve without compensation.

By law, the commission advises (1) DESPP's Division of State-Wide Emergency Telecommunications on the planning, design, implementation, and coordination of the statewide emergency 9-1-1 telephone system and (2) in consultation with the DESPP Coordinating Advisory Board, DESPP's commissioner on the planning, design, implementation, coordination, and governance of the public safety data network.

The current commission members are (1) the state fire administrator; (2) one representative each from the State Police's technical support services unit, Office of Emergency Medical Services, Department of

Emergency Management and Homeland Security, Connecticut Conference of Municipalities, and Council of Small Towns; and (3) one municipal police chief, municipal fire chief, volunteer firefighter, telecommunicator representative, representative of the public, manager or coordinator of a 9-1-1 public safety answering point, and commercial radio service provider representative.

EFFECTIVE DATE: October 1, 2022

§ 32 — DESPP COORDINATING ADVISORY BOARD

Expands the DESPP Coordinating Advisory Board by adding the DMHAS commissioner as a member

The bill expands, from 16 to 17, the membership of the DESPP Coordinating Advisory Board by adding the DMHAS commissioner. This board advises DESPP on ways to improve emergency response communications and related issues. Its current membership includes representatives from fire, police, health, emergency services, and municipal bodies. The DESPP commissioner serves as the chairperson.

EFFECTIVE DATE: October 1, 2022

§§ 33 & 34 — 9-8-8 SUICIDE PREVENTION AND MENTAL HEALTH CRISIS LINE

Establishes a 9-8-8 Suicide Prevention and Mental Health Crisis Lifeline Fund and a process for assessing a monthly fee (up to 75 cents per month per access line) on various telecommunications subscribers for deposit into the fund; sets a corresponding fee on prepaid wireless services

A 2020 federal law (P.L. 116-172) designated 9-8-8 as the national suicide prevention and mental health crisis hotline, scheduled to be operational on July 16, 2022. Federal law allows states to impose fees for providing 9-8-8 related services, as long as the fees are held in a designated account to be spent only for these purposes.

The bill establishes (1) a separate fund under state law to pay for 9-8-8 services, including call routing and mental health crisis outreach and stabilization services and (2) a process for assessing a related fee, after federal funds have been exhausted, on telecommunications subscribers and prepaid wireless purchasers.

EFFECTIVE DATE: October 1, 2022

9-8-8 Fund (§ 33)

The bill establishes a 9-8-8 Suicide Prevention and Mental Health Crisis Lifeline Fund, administered by DMHAS, to fund the National Suicide Prevention Lifeline's suicide prevention services. The fund must be used only for (1) ensuring the efficient routing of in-state calls made to 9-8-8 and (2) employing or contracting with mental health personnel to directly respond to these calls and provide acute mental health crisis outreach and stabilization services in response.

The bill requires that the following be deposited or transferred into the fund:

1. the statewide 9-8-8 fee assessed on telecommunications subscribers (see below);
2. any General Fund appropriation to DMHAS directed to the fund;
3. any federal funds directed to the state relating to 9-8-8;
4. any grants or gifts intended for the fund;
5. fund interest, premiums, gains, or other earnings; and
6. money from any other source intended for the fund's purposes.

The bill provides that money remaining in the fund at the end of a fiscal year remains in the fund, rather than reverting to the General Fund. It also prohibits any money in the fund from being transferred or otherwise diverted to other purposes.

The bill requires the DMHAS commissioner to determine the amount of funding needed to accomplish the fund's purposes. She must first do this, within a period she determines, to ensure the fund has enough available funds for FY 24 (i.e., the FY starting July 1, 2023); after that, she must determine this amount by April 1 of each year (presumably, for the subsequent FY). When making this determination, she must consider any amounts remaining in the fund. She must report on her

determination to the Public Utilities Regulatory Authority (PURA), within 30 days after her determination for FY 24 and by May 1 for following years.

The bill requires the DMHAS commissioner to annually report on the fund's deposits and expenditures beginning by January 1, 2024, to the (1) Federal Communications Commission (FCC) and (2) Appropriations, Public Health, Human Services, and Children's committees.

Telecommunications Subscriber 9-8-8 Fee (§ 33)

The bill requires PURA to establish a monthly assessment on each subscriber of the following services: local telephone, commercial mobile radio (e.g., cellphone), and voice over internet protocol (VOIP; e.g., Skype). The assessment's purpose is to fund suicide prevention services.

Starting by June 1, 2023, PURA must conduct a proceeding annually to determine the amount of the assessment, which cannot exceed 75 cents per line per month. PURA must base the fee on the DMHAS commissioner's findings and take into consideration money available in the 9-8-8 fund. The bill prohibits PURA from assessing the fee until all federal funds in the 9-8-8 fund have been exhausted.

Under the bill, after the fee takes effect, the companies providing these telecommunication services must assess the fee against their subscribers. The companies must remit the fee to the Office of the State Treasurer for deposit into the 9-8-8 fund by the 15th day of each month.

The bill allows these companies to combine the fee with the existing 9-1-1 fee into a single fee, identified as the "Combined 988/911 System Fee" on customer bills. If a company chooses to do this, it must separately report and remit the two fees to the treasurer's office for deposit into the respective funds.

The bill provides that the PURA-established assessment must be the only 9-8-8 funding obligation imposed on local telephone, commercial mobile radio, or VOIP services. It prohibits the state, political subdivisions, or intergovernmental agencies from imposing against

providers, sellers, or consumers any other fees, taxes, surcharges, or other charges for 9-8-8 funding purposes.

The bill also immunizes these companies or providers from liability to anyone for releasing information or failure of any equipment or procedure in connection with (1) routing in-state 9-8-8 calls or (2) employing or contracting with mental health personnel to directly respond to these calls and provide acute crisis outreach and stabilization services. This immunity applies to the companies or providers and their officers, directors, employees, vendors, or agents.

Prepaid Wireless 9-8-8 Fee (§ 34)

Similar to existing law for the 9-1-1 fee, the bill creates a separate assessment method for people who buy prepaid wireless telecommunications service with a per-transaction assessment. This fee must be equal to the monthly 9-8-8 fee PURA assesses on other telecommunications service subscribers. If a consumer purchase includes multiple prepaid services, each individual service constitutes a retail transaction.

The bill defines "prepaid wireless telecommunications service" as such a service that a consumer pays for in advance, allowing him or her to access the E 9-8-8 system by dialing or otherwise accessing 9-8-8. The service is sold in predetermined units or dollars that decline with use. The bill defines a "provider" as anyone who provides prepaid wireless telecommunications service under an FCC license.

Fee Collection and Remittance. The bill requires in-state retail sellers to collect the prepaid wireless 9-8-8 fee from consumers when they buy prepaid wireless communications services. A retail transaction occurs in Connecticut if (1) it is made in the consumer's presence at the retailer's business place in Connecticut or (2) the customer's shipping address or, if no item is shipped, his or her billing address or the location associated with his or her mobile phone number, is in Connecticut.

Retailers must disclose the fee amount to consumers in an invoice, a receipt, or other similar document, or post it conspicuously on their

websites or on a conspicuous sign at the point of sale. The bill allows sellers to combine the fee with the existing 9-1-1 fee into a single fee, identified as the "Combined 988/911 System Fee" in these same ways (e.g., an invoice or sign). The seller then must separately report and remit the fees to the Office of the State Treasurer.

Liability for Fees. The bill makes consumers liable for paying the prepaid wireless 9-8-8 fee. It provides that sellers and service providers have no liability, except sellers must remit any fees they are required to collect, including any fees not stated separately on an invoice, receipt, or other similar document they give to the consumer.

Treatment for Tax Purposes. Under the bill, the amount of the prepaid wireless 9-8-8 fee that sellers collect must be excluded from the base for measuring any tax, fee, surcharge, or other charge that the state, any political subdivision, or any intergovernmental agency imposes on the seller. This applies as long as the seller separately states the amount in an invoice, receipt, or other similar document provided to the consumer.

§ 35 — PSAP PROCEDURES FOR 9-1-1 CALLS

Requires DESPP, together with DMHAS, DCF, and DPH, to recommend a plan to incorporate mental and behavioral health and substance use disorder diversion into PSAP procedures for 9-1-1 calls and report it to the legislature by January 1, 2023

The bill requires the Department of Emergency Services and Public Protection (DESPP), in consultation with DMHAS, DCF, and DPH, to develop a plan for incorporating mental and behavioral health and substance use disorder diversion into the procedures public safety answering points (PSAPs) use to dispatch emergency response services in response to 9-1-1 calls. The plan must include recommendations for the following:

1. staffing PSAPs with licensed mental and behavioral health and substance abuse disorder service providers to (a) provide crisis counseling to 9-1-1 callers who immediately require these services, (b) assess their need for ongoing services, and (c) if needed, refer them to service providers;

2. transferring callers who require these services to responders, other than law enforcement (e.g., community organizations, mobile crisis teams, local organizations, or networks), who provide telephone support or referral services for people with mental or behavioral health needs or a substance use disorder;

3. requiring PSAPs to coordinate with DMHAS during the state's transition of mental health crisis and suicide response from the United Way's 2-1-1 Infoline program to the National Suicide Prevention Lifeline's 9-8-8 program;

4. developing protocols for transferring 9-1-1 calls to the 9-8-8 line when it is operational;

5. setting standards for training telecommunicators (i.e., 9-1-1 emergency dispatchers) to respond to 9-1-1 callers who may require mental or behavioral health or substance use disorder services;

6. collecting data to evaluate the effectiveness of procedures used to divert 9-1-1 callers who may need these services to the appropriate crisis hotline or services provider; and

7. evaluating other states' or jurisdictions' implementation of these procedures.

The DESPP commissioner must, by January 1, 2023, report on the plan's development and implementation recommendations and timeline to the Public Safety and Security, Public Health, and Children's committees.

EFFECTIVE DATE: Upon passage

§ 36 — CERTIFICATE OF NEED FOR MENTAL HEALTH FACILITIES

(1) Temporarily exempts, from CON requirements, increases in the licensed bed capacity of mental health facilities under certain conditions and (2) requires OHS to report on recommendations for establishing an expedited CON process for mental health facilities

Generally, existing law requires health care facilities to apply for and receive a certificate of need (CON) from the Office of Health Strategy's

(OHS) Health Systems Planning Unit when proposing to (1) establish a new facility or provide new services, (2) change ownership, (3) purchase or acquire certain equipment, or (4) terminate certain services.

Under certain conditions, the bill exempts from CON requirements increases in the licensed bed capacity of mental health facilities, through June 30, 2026.

It also requires the OHS executive director, by January 1, 2025, to report to the governor and the Public Health Committee her recommendations on establishing an expedited CON process for mental health facilities.

EFFECTIVE DATE: Upon passage

Temporary CON Exemption for Increases in Bed Capacity

To be eligible for the bill's temporary CON exemption, a mental health facility must demonstrate to the Health Systems Planning Unit, in a form the unit prescribes, that it accepts reimbursement for any covered benefit to covered individuals under certain types of private or public insurance plans. Specifically, this applies to:

1. individual or group health insurance policies that cover (a) basic hospital expenses; (b) basic medical-surgical expenses; (c) major medical expenses; or (d) hospital or medical services, including those provided under an HMO plan;

2. self-insured plans under the federal Employee Retirement Income Security Act (ERISA); and

3. HUSKY Health (i.e., Medicaid and the state children's health insurance program).

The exemption ends if the mental health facility does not accept or stops accepting reimbursement for any covered benefit under such a policy, plan, or program.

The bill requires the OHS executive director, by September 1, 2022, to develop application procedures for the exemption. These procedures

must require the applicant to notify OHS of the facility's address and describe all current or planned services at the facility.

Additionally, the facility's owner or operator must report to the OHS executive director at least every six months after increasing the licensed bed capacity (or establishing the facility). The reporting must address the care provided at the facility and, where available, the demographics of service recipients, including the number of these people, their age, and their municipality of residence.

§ 37 — DCF GRANT PROGRAM FOR CERTAIN MENTAL AND BEHAVIORAL HEALTH TREATMENT COSTS

Requires the DMHAS commissioner, by October 1, 2022, to establish a grant program to assist with the costs of obtaining prescribed drugs or treatments and intensive services for children with mental and behavioral health conditions if insurance or Medicaid does not cover them

Program Purpose

The bill requires the DMHAS commissioner, by October 1, 2022, to establish a grant program to help families with the cost of obtaining prescription drugs or certain treatment and intensive services for children to treat a mental or behavioral health condition if insurance or Medicaid does not cover the cost.

Under the bill, the intensive services include intensive evidence-based services or other intensive services to treat mental and behavioral health conditions in children and adolescents, including intensive in-home child and adolescent psychiatric services and services provided by an intensive outpatient program.

Program Eligibility

The bill requires the DMHAS commissioner, in consultation with the Department of Consumer Protection (DCP) commissioner, to administer and establish the grant program eligibility requirements and determine the grant amounts.

Under the bill, the eligibility requirements (1) must include that a family's health carrier has denied coverage or reimbursement for the drug or treatment or for intensive services and (2) may include the

family's financial need.

An eligible family may apply to the OPM secretary for a grant when and how the DMHAS commissioner determines.

Posting Grant Program Description on the Departments' Website

The bill requires DMHAS, DCP, and OPM to post in a conspicuous location on their respective websites the grant program's description, including the eligibility requirements and application process. The OPM secretary may request that another state agency also post this information on its website.

Reporting and Regulations

The bill (1) requires the DMHAS commissioner to annually report on the program's effectiveness to the Public Health Committee, starting by January 1, 2024, and (2) authorizes her to adopt implementing regulations.

EFFECTIVE DATE: Upon passage

§ 38 — PEDIATRIC MENTAL HEALTH SCREENING TOOL

By January 1, 2023, requires DPH to develop or procure a screening tool to help pediatricians and emergency room doctors diagnose mental health, behavioral health, or substance use disorders in children

The bill requires DPH, by January 1, 2023, to develop or procure a pediatric mental health, behavioral health, and substance use disorder screening tool. DPH must do so in consultation with a Connecticut children's hospital representative and the Connecticut chapter of a national professional association of (1) pediatricians and (2) child and adolescent psychiatrists.

The screening tool must include questions geared toward helping a child's pediatrician or an emergency department physician with diagnosing common mental and behavioral health conditions and substance use disorders that may require specialized treatment. It must be completed by a child and, where appropriate, the child's parent or guardian before or during the child's pediatric appointment or during the child's emergency department visit.

By January 1, 2023, the bill requires DPH, in collaboration with DCF and DMHAS, to 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. It requires pediatricians and emergency department physicians to use the screening tool as a supplement to the existing methods used to diagnose a mental or behavioral health condition or a substance use disorder.

Under the bill, pediatricians must provide the screening tool to each patient annually, and emergency department physicians must (1) provide the screening tool to each emergency department patient under age 18, or the parents or guardian, before the child's discharge from the emergency department and (2) send a copy of it to the child's pediatrician or primary care provider to the extent possible and as soon as practicable.

EFFECTIVE DATE: Upon passage

§§ 39-41 — PEER-TO-PEER MENTAL HEALTH SUPPORT PROGRAM

Requires DCF, in collaboration with SDE, to develop a peer-to-peer mental health support program for students in grades 6 - 12; authorizes local and regional boards of education and certain other entities to administer the program in grades 6 – 12, beginning with the 2023-2024 school year

The bill requires DCF, in collaboration with SDE, to make a peer-to-peer mental health support program available to (1) local or regional boards of education, (2) local and district health departments, (3) youth service bureaus, (4) municipal social service agencies, and (5) other DCF-approved youth-serving organizations. The bill requires the departments to:

1. by January 1, 2023, develop a peer-to-peer mental health support program that provides services to help students in grades 6 through 12 with problem solving, decision making, conflict resolution, and stress management; and

2. beginning January 1, 2023, provide training to designated staff members and employees on the program's implementation and

student instruction, guidance, and supervision.

In developing the program, DCF must use best practices and may use any existing models of peer-to-peer counseling.

Under the bill, beginning with the 2023-2024 school year, local and regional boards of education, as well as the entities described above, may begin administering the program to participating students in grades 6-12. The superintendent for each district administering the program must select at least one "designated staff member" to complete the DCF-SDE training (i.e., a teacher, school administrator, guidance or school counselor, psychologist, social worker, nurse, physician, or school paraeducator (1) employed by a local or regional board of education or (2) working in a public middle or high school). The other entities administering the program must select at least one employee to do so as well.

EFFECTIVE DATE: July 1, 2022

§ 42 — DCF IN-HOME RESPITE CARE SERVICES PROGRAM

Requires the DCF commissioner to establish and administer an in-home respite care services program for children with behavioral health needs; establishes an account within the General Fund to fund the program

The bill requires the DCF commissioner, by January 1, 2023, to establish a program to provide in-home services to parents and guardians of children with behavioral health needs (i.e., 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") to provide them respite from caregiving.

Under the bill, DCF must administer the program through service contracts with providers of such services or through direct subsidies to the caregivers to enable them to purchase such services.

The bill establishes a "Department of Children and Families in-home respite care services fund" as a separate, nonlapsing account within the General Fund. The account must contain any money required by law to

be deposited into it. The bill requires the DCF commissioner to use the account to fund the DCF in-home respite care services program.

The bill also requires the DCF commissioner to adopt regulations to implement the bill's provisions, including eligibility criteria for in-home respite care services program participation.

EFFECTIVE DATE: July 1, 2022

§§ 43 & 44 — CONNECTICUT HIGHER EDUCATION SUPPLEMENTAL LOAN AUTHORITY (CHESLA) TECHNICAL CHANGE

Makes a technical change to the definition of "eligible loan"

The bill makes a technical change the CHESLA definition of "eligible loan."

Under current law, for purposes of the CHESLA laws, "eligible loan" means a higher education loan that is in repayment that was made (1) by CHESLA or (2) to a borrower by a private or governmental lender. The bill specifies that governmental lenders include the federal government.

EFFECTIVE DATE: July 1, 2022, except the technical change relating to an expanded definition is effective October 1, 2022, to conform with the definition's effective date (§ 44).

§ 45 — MENTAL HEALTH CARE PROVIDER LOAN FORGIVENESS PROGRAM

Requires CHESLA, in consultation with DPH, to administer a mental health care provider loan forgiveness program

The bill requires CHESLA, in consultation with DPH, to administer a mental health care provider loan forgiveness program, within available appropriations, beginning in FY 23. Under the program, CHESLA must forgive any balance of the consolidation loan for borrowers who meet the eligibility requirements described below. CHESLA's executive director determines when and how program applicants may apply.

Eligible borrowers must meet the following requirements:

1. be a licensed physician, surgeon, physician assistant, behavior analyst, psychologist, martial and family therapist, clinical or master social worker, professional counselor or professional counselor associate, psychology technician, music therapist, or art therapist in Connecticut;

2. be a Connecticut resident or establish state residency within five years after applying for the program;

3. provide mental health care services primarily to Connecticut residents;

4. consolidate federal or state educational loans through CHESLA (as a state entity, CHESLA does not have authority to consolidate federal loans; see COMMENT section, below);

5. complete 84 consecutive on-time payments of the consolidation loan under an income-driven repayment plan; and

6. be employed in a mental health care provider shortage area, as designated by the DPH commissioner, when applying for student loan consolidation.

The bill allows a provider to change employment or licensure after applying for loan consolidation or loan forgiveness and still receive forgiveness, so long as the provider satisfies the above eligibility requirements. Also, CHESLA must reserve 33% of the state appropriations received for the program's administration for eligible borrowers who establish Connecticut residency within five years after the date on which they submitted their program application.

Additionally, the bill requires CHESLA's executive director to report to the Public Health Committee by January 1, 2023, and annually thereafter, on the loan forgiveness program's usage and effectiveness.

EFFECTIVE DATE: July 1, 2022

§ 46 — CHILD PSYCHIATRIST GRANT PROGRAM

Requires DPH to establish a child psychiatrist grant program, providing incentive grants to employers for recruiting, hiring, and retaining child psychiatrists; establishes an advisory board within DPH to advise on the program and approve employers that DPH selects to receive grants

The bill requires DPH, by January 1, 2023, to establish and administer a grant program to incentivize employers of child psychiatrists to recruit and hire new child psychiatrists and retain those whom they employ. It requires the commissioner to adopt program administration regulations, including ones establishing eligibility requirements, priority categories, funding limitations, and application processes.

By January 1, 2023, the bill also establishes a child psychiatrist grant program advisory board within DPH. The board must (1) advise the department on the effective use of the incentive program's grant funds and (2) approve each employer that DPH selects to receive a grant.

Under the bill, the board is comprised of six members, one appointed by each of the six legislative leaders. Legislators cannot serve on the board, and board members (or their spouses, parents, or children) cannot apply for or receive a program grant. The House speaker and Senate president pro tempore must each select a co-chairperson from among the board members.

The bill makes board members' term length coterminous with their appointing authority. There is no term limit. The appointing authority fills any vacancy, and any vacancy occurring other than by the term's expiration is filled for the unexpired term's balance. A majority of the membership constitutes a quorum for transacting any board business. The administrative staff of the State Auditors of Public Accounts serve as the board's administrative staff.

Staring by January 1, 2024, the advisory board's co-chairpersons must annually report to the Public Health Committee on (1) the number and demographics of the employers who applied for and received incentive grants under the program, (2) the recipients' use of grant funds, and (3) any other information the board considers pertinent.

EFFECTIVE DATE: Upon passage

§ 47 — DMHAS ADVERTISING CAMPAIGN

Requires DMHAS, in collaboration with DCF, to (1) plan and implement a statewide advertising campaign on the availability of mental or behavioral health and substance use disorder services in the state and (2) set up a comprehensive website with related information

The bill requires DMHAS, by January 1, 2023, and in collaboration with DCF, to design, plan, and implement a multiyear, statewide advertising campaign (1) promoting the availability of all mental health, behavioral health, and substance use disorder services in the state, including the difference between 9-1-1, 9-8-8, and 2-1-1, and (2) informing residents how to obtain these services. The campaign must at least include television, radio, and online advertising.

In addition, DMHAS, by this same date and in collaboration with DCF, must establish and regularly update a website connected with this advertising campaign that includes a comprehensive listing of in-state providers of these services.

The bill requires the DMHAS commissioner to solicit cooperation and participation from these providers in this advertising campaign, including soliciting any available funds. It allows the commissioner to hire consultants with advertising expertise to assist in implementing these provisions.

EFFECTIVE DATE: Upon passage

§ 48 — PEER-TO-PEER SUPPORT PROGRAM FOR CAREGIVERS

Requires DCF, in collaboration with DMHAS, to establish a grant program to create a peer-to-peer support program for parents and caregivers of children with behavioral health needs

By January 1, 2023, the bill requires DCF, in collaboration with DMHAS, to establish a grant program for inpatient and outpatient children's mental and behavioral health care programs to create a peer-to-peer support program for parents and caregivers of children with mental and behavioral health issues. Under the bill, the DCF commissioner must adopt regulations for grant program administration, including eligibility requirements, priority categories, funding limitations, and the program application process.

EFFECTIVE DATE: Upon passage

§§ 49 & 50 — MENTAL HEALTH WELLNESS EXAMS

Requires certain health insurance policies to cover two mental health wellness examinations per year with no patient cost sharing or prior authorization requirements

The bill requires certain health insurance policies to cover two mental health wellness examinations per year conducted by a licensed mental health professional or primary care provider. The examinations must be provided with no patient cost-sharing (i.e., no coinsurance, copay, or deductible) or prior authorization requirements.

Under the bill, a "mental health wellness examination" is a screening or assessment to identify any behavioral or mental health needs and appropriate treatment resources. It may include:

1. observation;

2. a behavioral health screening;

3. education and consultation on healthy lifestyle changes;

4. referrals to ongoing treatment, mental health services, and other necessary supports;

5. discussion of potential medication options;

6. age-appropriate screenings or observations to understand the insured's mental health history, personal history, and mental or cognitive state; and

7. relevant input from an adult through screenings, interviews, or questions if appropriate.

Under the bill, a "licensed mental health professional" is one of the following licensed professionals: a professional counselor or certain people practicing under supervision, a physician certified in psychiatry, an advanced practice registered nurse (APRN) certified as a psychiatric and mental health clinical nurse specialist or practitioner, a psychologist, a marital and family therapist, a clinical social worker, or

an alcohol and drug counselor.

A "primary care provider" is a licensed physician, APRN, or physician assistant providing primary care services. The bill specifies that the examinations may be performed by a primary care provider as part of a preventative visit.

Coverage Applicability

The bill applies to fully-insured individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2023, that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans. (Although the state employee health insurance plan is self-insured, in practice, it adopts enacted benefit requirements.)

Cost Sharing Applicability

The bill's cost-sharing limitation applies to each plan described above. However, for plans that are high deductible health plans (HDHPs), it applies only to the maximum extent (1) permitted by federal law and (2) that does not disqualify someone who establishes a health savings account (HSA), medical savings account (MSA), or Archer MSA from receiving the associated federal tax benefits. Under federal law, individuals with eligible HDHPs may make pre-tax contributions to an HSA, MSA, or Archer MSA and use the account for qualified medical expenses.

EFFECTIVE DATE: January 1, 2023

§§ 51 & 52 — HEALTH INSURANCE COVERAGE FOR INTENSIVE SERVICES FOR MENTAL CONDITIONS

Requires certain health insurance policies to cover intensive evidence-based, rather than home-based, services to treat children's mental or nervous conditions and expands coverage to include adolescents

The bill requires certain health insurance policies to cover intensive

evidence-based services to treat a child's mental or nervous condition, instead of intensive home-based services as current law requires. Additionally, the bill expands this coverage to include adolescents, rather than only children as under current law.

The provisions apply to fully-insured individual or group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan.

By law, these health insurance policies cannot place a greater financial burden on an insured for seeking these services than for the diagnosis and treatment of medical, surgical, or other physical conditions.

EFFECTIVE DATE: January 1, 2023

§ 53 — SCHOOL-BASED MENTAL HEALTH CLINICS

Requires DCF, DPH, and SDE to develop a plan, potentially including school-based mental health clinics, to promote access to mental health services for children and youth in regions of the state that lack access to school-based health centers

The bill requires DCF, DPH, and SDE, by January 1, 2023, to develop a plan promoting access to mental health services for children and youth, which may include establishing school-based mental health clinics, in regions of the state that do not have access to school-based health centers or expanded school health sites. They must develop the plan in consultation with the Connecticut Association of School-Based Health Centers and a DCF-licensed children's mental health service provider.

The bill allows these services to include (1) providing counseling to individual students, groups, or families to the extent permitted by a sponsoring facility's license or certification; (2) extending the clinic's hours of operation to include after school, weekend, or summer hours based on community need for services; and (3) providing mental health programming for students in partnership with a local or regional board of education. Under the bill, "mental health programming" is age-

appropriate education or outreach initiatives aimed at students to prevent mental illness (e.g., poster and flyer campaigns, films, guest speakers, or other school events).

Under the bill, any mental health service provider staffing a school-based mental health clinic established in partnership with a board of education must be knowledgeable about social-emotional learning (see definition below) and restorative practices. Providers may receive additional training on these issues by participating in training provided by the boards to teachers and administrators under their jurisdiction.

By February 1, 2023, the bill requires DCF and DPH to jointly submit a report to the Children's Committee on the plan and any available funding sources for its implementation.

EFFECTIVE DATE: July 1, 2022

Definitions

School-Based Mental Health Clinic. Under the bill, a "school-based mental health clinic" is a clinic that:

1. 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;

2. is organized through school, community, and health provider relationships;

3. is administered by a sponsoring facility (e.g., a hospital, community health center, or school system); and

4. 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.

Social-Emotional Learning. By law, "social-emotional learning" is the process through which children and adults achieve emotional intelligence through the competencies of self-awareness, self-management, social awareness, relationship skills, and responsible

decision-making (CGS § 10-222v).

§ 54 — PSYCHOLOGY DOCTORAL STUDENT CLERKSHIP PROGRAM

Requires DPH to establish an incentive program for psychology doctoral students who complete a semester-long clerkship at DCF-licensed or -operated facilities or other agencies DCF deems appropriate

The bill requires DPH, by January 1, 2023, to establish an incentive program encouraging psychology doctoral degree candidates to serve at least one semester-long clerkship (1) at a DCF-licensed or -operated facility or (2) for other state agencies the DCF commissioner deems appropriate.

Under the bill, this clerkship requires the candidate to work 12 to 16 hours per week as a psychological assessor or psychotherapist under the supervision of an agency-affiliated psychologist and at least one core faculty member of the doctoral degree program. The candidate's program of study must be primarily psychological and must occur at an educational institution approved by DPH under existing law for psychologist licensure.

Under the bill, anyone who completes at least one of these clerkships at an eligible facility and is otherwise eligible for the bill's mental health care provider loan forgiveness program, is eligible for loan forgiveness after making 60 consecutive on-time qualifying payments, rather than 84 payments as is generally required under the bill (see § 45).

In addition, the bill allows anyone completing such a clerkship to renew his or her psychologist license every two years, rather than annually, during the first four years of licensure.

EFFECTIVE DATE: July 1, 2022

§ 55 — PROTOCOLS FOR EMS TRANSPORT

Requires the Office of Emergency Medical Services to develop protocols for EMS organizations or providers to transport pediatric patients with mental or behavioral health needs by ambulance to DCF-operated urgent care centers

The bill requires DPH's Office of Emergency Medical Services (OEMS) to develop protocols for licensed or certified emergency

medical services (EMS) organizations or providers to transport pediatric patients with mental or behavioral health needs by ambulance to DCF-operated urgent care centers. These centers must be dedicated to treating children's urgent mental or behavioral health needs. OEMS must develop these protocols by January 1, 2024.

Under the bill, as under existing law for EMS non-hospital transport, the ambulance must meet state regulatory requirements for a basic level ambulance, including requirements about medically necessary supplies and services.

EFFECTIVE DATE: October 1, 2022

§§ 56 & 57 — HEALTH INSURANCE COVERAGE FOR COLLABORATIVE CARE MODEL SERVICES

Requires certain health insurance policies to cover primary care provider services under a Collaborative Care Model (i.e., the integrated delivery of behavioral health and primary care services by a primary care team)

The bill requires certain health insurance policies to cover health care services that a primary care provider provides to an insured under the Collaborative Care Model. Under the bill, the "Collaborative Care Model" is the integrated delivery of behavioral health and primary care services by a primary care team that includes a primary care provider, behavioral care manager, and psychiatric consultant. It must also include a database the behavioral care manager uses to track patient progress.

Under the bill, this coverage must include services with the following Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, including any subsequent corresponding codes:

1. HCPCS G2214, an initial or subsequent psychiatric collaborative care management, in consultation with other collaborative care team professionals (i.e., tracking or following up on patient progress);

2. CPT 99484, clinical staff time for behavioral health care management conditions;

3. CPT 99492, an initial psychiatric collaborative care management;

4. CPT 99493, subsequent psychiatric collaborative care management; and

5. CPT 99494, additional initial or subsequent psychiatric collaborative care management.

The provisions apply to fully-insured individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans. (In practice, the state employee health insurance plan adopts enacted benefits.)

EFFECTIVE DATE: January 1, 2023

§§ 58-63 — HEALTH INSURANCE COVERAGE FOR ACUTE INPATIENT PSYCHIATRIC SERVICES

Broadly expands health insurance and emergency access to acute inpatient psychiatric services, including by (1) prohibiting balance billing, higher out-of-network billing, and prior authorization and (2) requiring 24-hour, 7-day per week access to services

Prior Authorization, Cost Sharing, and Maximum Billable Amounts (§ 58)

The bill prohibits health carriers from (1) requiring prior authorization for acute inpatient psychiatric services or (2) imposing a cost-sharing level for out-of-network acute inpatient psychiatric services that is greater than the in-network level.

The bill also establishes the maximum allowable billable and reimbursable amounts for out-of-network acute inpatient psychiatric services. For these services, a provider may bill (and a carrier must reimburse) up to the greatest of the: (1) in-network rate, (2) usual and customary rate, or (3) Medicare rate. As with existing law for out-of-network emergency services, a provider and carrier may agree to a higher reimbursement rate.

Prohibits Balance Billing (§§ 59 & 60)

The bill makes it a Connecticut Unfair Trade Practices Act (CUTPA) violation for a health care provider to "balance bill" an insured for covered out-of-network acute inpatient psychiatric services (i.e., bill more than the collectable cost-sharing under the policy).

The bill also prohibits any health care center (i.e., HMO) provider, agent, trustee, or assignee from requesting any payment from an enrollee for covered out-of-network acute inpatient psychiatric services, presumably excluding allowable cost sharing. It additionally requires all health care center contracts with providers to disclose that doing so is a CUTPA violation.

Among other things, CUTPA allows the consumer protection commissioner to investigate complaints, issue cease and desist orders, and order restitution in certain cases. It also allows individuals to sue. Courts may issue restraining orders; award actual and punitive damages, costs, and reasonable attorney's fees; and impose civil penalties of up to $5,000 for willful violations and $25,000 for restraining order violations.

Applicability (§ 58)

The provisions described above (i.e., prior authorization, cost sharing, billable amounts, and balance billing) apply to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan.

Full Week, 24-Hour Access to Services (§ 61)

By law, health carriers must provide covered people access to emergency services 24 hours per day, seven days per week. The bill requires carriers to also ensure that covered people have the same access to acute inpatient psychiatric services.

Expanded Treatment Coverage for Mental or Nervous Conditions (§§ 62 & 63)

By law and with the exception of emergency services or certain referrals, health care centers are not required to cover state-mandated treatments for mental or nervous conditions at unaffiliated facilities. By also excluding "acute inpatient psychiatric services," the bill requires health care centers to cover these services even when provided at unaffiliated facilities.

EFFECTIVE DATE: January 1, 2023

§ 58 — PROVIDERS TO NOTIFY HEALTH CARRIERS OF EMERGENCY SERVICES

Requires health care providers providing emergency services to notify an insured's health carrier within three days

The bill requires health care providers who render emergency services to an insured to notify the insured's health carrier within three calendar days.

EFFECTIVE DATE: January 1, 2023

§ 64 — OFFICE OF HEALTH STRATEGY REIMBURSEMENT RATE STUDY

Requires the Office of Health Strategy to study the rates at which Connecticut health carriers and third party administrators (TPAs) reimburse health care providers for physical, mental, and behavioral health benefits and report to the Insurance and Real Estate and Public Health committees by January 1, 2023

The bill requires the Office of Health Strategy (OHS) to study the rates at which Connecticut health carriers (e.g., insurers and HMOs) and third-party administrators (TPAs) reimburse health care providers for covered physical, mental, and behavioral health benefits under individual and group health insurance policies. The study must assess, at a minimum, the following:

1. the viability of implementing a sliding scale of reimbursement rates in the state,

2. the extent to which reimbursement rates for mental and behavioral health benefits would need to increase to (a) attract additional providers to provide covered mental and behavioral

health benefits and (b) encourage existing providers to accept new patients in the state,

3. the potential aggregate savings to health carriers if insureds had greater access to providers of covered mental and behavioral health benefits,

4. reimbursement rates for covered mental and behavioral health benefits paid by private health insurance policies compared with what the state or other governmental payors pay,

5. reimbursement rates for mental and behavioral health benefits provided to children compared with those provided to adults, and

6. the number of children referred for these benefits compared with the number of children who receive them.

The bill requires OHS to report its study results to the Insurance and Real Estate and Public Health committees by January 1, 2023.

EFFECTIVE DATE: Upon passage

§ 65 — OHS PAYMENT PARITY STUDY

Requires OHS, in consultation with the insurance commissioner, to study whether payment parity exists between (1) behavioral and mental health services providers and other medical services providers in both HUSKY Health and the private insurance market and (2) behavioral and mental health services providers in HUSKY Health compared to the private market

The bill requires OHS, in consultation with the insurance commissioner, to study 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. these providers within the HUSKY Health program (i.e., Medicaid and the state children's health insurance program); and

3. behavioral and mental health providers within the HUSKY Health program and the private insurance market.

The study must also include (1) what rate increases may be needed to encourage more private providers to offer behavioral and mental health services to HUSKY Health members, (2) an estimate of how much these increases would cost the state annually, and (3) potential state savings on other health care costs annually if HUSKY Health members had expanded access to these providers.

By January 1, 2023, the OHS executive director must submit a report on the study's findings to the Human Services, Insurance, Public Health, and Appropriations committees.

EFFECTIVE DATE: Upon passage

§ 66 — MEDICAID REIMBURSEMENT SYSTEM

Requires DSS to implement a Medicaid reimbursement system that reimburses providers separately to incentivize collaboration between primary care providers and behavioral health and mental health care providers

The bill requires, to the extent permitted under federal law, the Department of Social Services (DSS) to implement a Medicaid reimbursement system that separately reimburses each provider consulting on a HUSKY Health member's integrated care plan to incentivize collaboration between primary care providers and behavioral and mental health care providers.

The bill allows the DSS commissioner to adopt the Collaborative Care Model (CoCM) to expand access to behavioral and mental health services for HUSKY Health members. Under the bill, CoCM is the integrated delivery of behavioral health and primary care services by a primary care team that includes a (1) primary care provider, (2) behavioral care manager, (3) psychiatric consultant, and (4) database used by the behavioral care manager to track patient progress. The bill allows the DSS commissioner to reimburse participating providers using CoCM codes developed and approved by the Centers for Medicare and Medicaid Services to provide Medicare rates for services provided under CoCM.

By law, HUSKY Health includes Medicaid (HUSKY A, C, and D) and the Children's Health Insurance Program (HUSKY B) (CGS § 17b-290).

EFFECTIVE DATE: July 1, 2022

§ 67 — YOUTH SERVICE CORPS PROGRAM AND GRANTS

Establishes a Youth Service Corps program administered by DECD to provide grants to certain municipalities to provide paid community-based service learning and academic and workforce development programs to eligible youth and young adults

The bill establishes a Youth Service Corps program to provide grants to certain municipalities to establish local programs that provide paid, community-based service learning and academic and workforce development programs to eligible Connecticut youth and young adults (i.e., local Youth Service Corps programs). The Department of Economic and Community Development (DECD) must administer the grant program.

By October 1, 2022, the DECD commissioner must develop a grant application process and selection criteria, and municipalities must submit applications in a form and manner the commissioner prescribes. For a municipality to be eligible for a Youth Service Corps program grant, it must have a priority school district and operate, establish, or demonstrate plans to establish a local Youth Service Corps program. The bill requires the local program to conform to parameters the bill sets (see below).

By January 1, 2023, and annually thereafter, the DECD commissioner must award grants to municipalities selected to participate in the program in the amount of $10,000 per participant plus 15% of the amount for program administration expenses. Under the bill, the municipalities may use the grants to (1) administer the local Youth Service Corps program and (2) award a sub-grant of no more than $10,000 to any program participant to support or subsidize participation in program activities.

Beginning by December 1, 2023, and annually thereafter, each municipality that received a grant must submit a report on its local Youth Service Corps program to the DECD and DCF commissioners in a form and manner the DECD commissioner prescribes.

The bill requires the DECD commissioner, in consultation with the

DCF commissioner, to annually report, beginning by January 1, 2024, to the Commerce and Children's committees on the Youth Service Corps program.

EFFECTIVE DATE: July 1, 2022

Participant Eligibility

Under the bill, program participants must be youths or young adults age 16 to 24 who are showing signs of disengagement or disconnection from school, the workplace, or the community. The program must target, at a minimum, youth or young adults (1) involved with the justice system or DCF, (2) in foster care, or (3) experiencing homelessness.

The bill requires (1) participation by referral only and (2) that referrals be made by a school official, juvenile probation officer, the DCF commissioner or her designee, or a community organization employee whom the municipality or its Youth Service Corps program administrator designates to make referrals. Municipalities must allow local school officials and the DCF commissioner or her designee to refer a youth or young adult to its local Youth Service Corps program.

Each participant must develop an individual success plan to identify education, workforce, or behavioral development goals. Program participants are measured by performance indicators applicable to them, including education outcomes, career competency development, training completion, and positive behavior changes.

Program Administration

The bill requires a local, community-based organization with expertise in providing youth or young adult services and workforce development programs to administer the local Youth Service Corps program. The organization must work with local municipal officials to identify potential local service project opportunities.

Under the bill, each local Youth Service Corps program must provide the following:

1. year-long, part-time employment with flexible hours with public or private employers the program administrator screens and approves,

2. community-based service learning projects the program administrator selects,

3. a transition plan for the participant detailing goals and steps to be taken to accomplish them, and

4. other activities the program administrator approves.

§§ 68 & 69 — PERMANENT INSURANCE COVERAGE FOR TELEHEALTH SERVICES

Beginning July 1, 2024, permanently requires insurance policies to cover services provided through telehealth to the same extent that they cover them when provided in person by a Connecticut-licensed provider, rather than by any provider

Beginning July 1, 2024, following the sunset of the temporary insurance coverage provisions noted above in Sections 14-16, the bill permanently requires certain health insurance policies to cover medical advice, diagnosis, care, or treatment provided through telehealth to the same extent that they cover those services when provided in person by a health care provider licensed in Connecticut. Current law requires the coverage to the extent the service is covered in person by any provider.

The bill applies to fully insured individual and group health insurance policies that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. (Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.)

EFFECTIVE DATE: July 1, 2024

§§ 70-72 — INFORMATION ON CHILDREN'S MENTAL HEALTH AND DOMESTIC VIOLENCE

Sets new distribution requirements for the (1) DCF children's behavioral and mental health resources document and (2) judicial branch's Office of Victim Services (OVS) domestic violence victim resources document

The bill establishes new requirements related to the development and distribution of the existing (1) DCF children's behavioral and mental health resources document and (2) judicial branch's Office of Victim Services (OVS) domestic violence victim resources document (see *Background*, below).

The bill requires OVS, starting by December 1, 2022, to annually do the following:

1. provide its victim resources document (see below) in multiple languages, including English, Polish, Portuguese, and Spanish;

2. distribute the document electronically to the State Department of Education (SDE); and

3. distribute it electronically and in hard copy to the Department of Emergency Services and Public Protection (DESPP), each municipal police department, and each ambulance company and organization that offers transportation or treatment services to patients under emergency conditions.

Starting January 1, 2023, the bill also does the following:

1. requires state and municipal police officers and emergency medical technicians, including medical responders, to keep copies of the DCF and OVS documents in any vehicle they use to carry out their duties;

2. allows the police officers and emergency medical technicians to provide a copy of the documents to anyone, including a victim's family member, whom the officer or technician determines may benefit from the services or resources described in them; and

3. requires peace officers at the scene of a family violence incident to provide victims with the OVS victim resource document and, if there is a child at the scene, a copy of the DCF children's resources document containing children's mental health resources in the victim's mental health region.

EFFECTIVE DATE: July 1, 2022

Background — DCF Children's Behavioral and Mental Health Resources Document

Under existing law, the Department of Children and Families (DCF), must develop a document for each mental health region describing the behavioral and mental health evaluation and treatment resources available to children in their respective mental health regions.

Background — OVS Domestic Violence Victim Resources Document

Existing law requires OVS, in consultation with the Connecticut Coalition Against Domestic Violence, to compile information on domestic violence victim services and resources and provide it to SDE.

Background — Related Bill

HB 5154, voted favorably by the Children Committee, contains similar provisions.

§§ 73 & 74 — VICTIM COMPENSATION PROGRAM EXPANSION

Expands the Victim Compensation Program by extending eligibility to victims of child abuse or neglect substantiated by DCF and victims of certain other crimes against minors

By law, a victim may be eligible for crime victim compensation if he or she sustained personal injury or died as a result of (1) a crime as defined under Connecticut law; (2) a crime that occurred outside the territorial boundaries of the United States, if it would be considered a crime in Connecticut and the victim is a Connecticut resident; or (3) a crime involving international terrorism as defined by federal law.

The bill expands eligibility for compensation under the program to victims of child abuse or neglect substantiated by DCF. It also requires the DCF or children's advocacy center employee to whom such an injury was disclosed to notify the victim or the victim's parent, guardian, or legal representative, both verbally and in writing, about the (1) victim's eligibility for the program, (2) program application process, and (3) types and amounts of compensation that may be awarded. The bill does not specify a time frame within which the notification must be made.

Additionally, under existing law, the Office of Victim Services or, on review, a victim compensation commissioner, may order compensation to be paid to certain victims (e.g., trafficking victims) if the (1) personal injury has been (a) disclosed to certain professionals, such as a doctor, DCF worker, or guidance counselor or (b) reported in a retraining or civil protection order application and (2) office or commissioner reasonably concludes that the violation occurred. The bill expands eligibility under these conditions to victims of commercial sexual abuse of a minor, enticing a minor, obscenity as to a minor, employing or promoting a minor in an obscene performance, and commercial sexual exploitation of a minor.

EFFECTIVE DATE: July 1, 2022

Background — Victim Compensation Program

By law, the judicial branch's Office of Victim Services (OVS) administers the state's Victim Compensation Program. The maximum program payments are $15,000 for personal injury; $25,000 for survivor benefits; and $5,000 for emotional harm (CGS § 54-211(d)(1)). However, OVS or a victim compensation commissioner may award amounts above the statutory maximum for good cause shown and upon a finding of compelling equitable circumstances (CGS § 54-211(d)(3)).

Background — Related Bill

sHB 5238, favorably reported by the Children's Committee, has identical provisions.

§ 75 — SPECIAL EDUCATION ELIGIBILITY FOR SOCIAL EMOTIONAL DISABILITIES

Extends protections, processes, and services available under special education law to students with social emotional disabilities and their parents and guardians

The bill amends the current definition of "children requiring special education" in state law by adding exceptional children with "social emotional disabilities." By law, an "exceptional child" is one who deviates intellectually, physically, or emotionally so markedly from normally expected growth and development patterns that he or she is or will be unable to progress in a regular school program and needs a

special class, instructions, or services.

The bill defines the term "social emotional disability" as a condition that adversely affects a child's educational performance and exhibits one or more of the following characteristics over a long period of time and to a marked degree:

1. an inability to learn that cannot be explained by intellectual, sensory, or health factors;

2. an inability to build or maintain satisfactory interpersonal relationships with peers and teachers;

3. inappropriate types of behavior or feelings under normal circumstances;

4. a general pervasive mood of unhappiness or depression; and

5. a tendency to develop physical symptoms or fears associated with personal or school problems.

The bill specifies that the development of a social emotional disability requires programs or services beyond the level of those ordinarily provided in regular school programs but may be provided through special education as part of the public school program.

Students who become eligible for special education under this new disability category, and their parents or guardians, are entitled to protections, processes, and services available under special education law, which local and regional boards of education must provide until they graduate high school or reach age 21, whichever happens first. This includes the following, among other things:

1. a "child find" obligation on the district to identify students with social emotional disabilities and determine their eligibility for special education (CGS § 10-76d(a)(1));

2. a planning and placement team (PPT) meeting process to determine special education eligibility, placement, and services

(CGS § 10-76d(a)(10));

3. an individualized educational program (IEP) in effect at the beginning of each school year (CGS § 10-76d(a)(10)(E));

4. a PPT-developed statement of transition service needs in the student's IEP, beginning by age 14 or earlier (CGS § 10-76d(a)(9));

5. placement with an approved private special education provider if the school district and state cannot provide appropriate services (CGS § 10-76d(d)); and

6. the right for the student's parent or guardian to request a board of education meeting and subsequent state administrative hearing to appeal the board's or district's refusal to initiate or change the student's identification, evaluation, or educational placement (CGS § 10-76h).

Additionally, school districts can do the following due to the bill's creation of a new special education disability category:

1. factor in children requiring special education services for a social emotional disability when calculating their special education excess cost grant from the state (CGS §§ 10-76f & 10-76g) and

2. be eligible for a school construction grant for purchasing or constructing a facility to be used as a cooperative regional special education facility for students with a social emotional disability (CGS § 10-76e).

EFFECTIVE DATE: July 1, 2022

§§ 76-79 & 81 — DCF APPROPRIATIONS FOR FY 23

Appropriates money from the General Fund to DCF for specified purposes and authorizes the department to use certain funds to provide mental or behavioral services to children

For FY 23, the bill appropriates $6.5 million from the General Fund to DCF's Community Kidcare and Family Support Services accounts for grants to certain providers (§ 76) (see below).

The bill also authorizes DCF, each fiscal year starting with FY 23, to use the department's funds, including any authorized bond funds, to increase the number of (1) 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 (2) beds available to the children through these providers, programs, and facilities (§ 79).

Additionally, it appropriates for FY 23 an unspecified amount of funds to DCF from the General Fund to hire and retain employees engaged full-time in mental or behavioral clinical work (§ 81).

Community Kidcare Account (§ 77)

The $6.5 million appropriated to DCF for FY 23 must be available to the department in its Community Kidcare account for grants to providers to do the following:

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 where emergency mobile psychiatric services personnel provide emergency mobile psychiatric services to children,

3. expand the hours of operation during which these services are provided to children, and

4. expand the training of personnel providing emergency mobile psychiatric services to children.

Family Support Services Account (§ 78)

The $6.5 million appropriated to DCF for FY 23 must also be made available to the department 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 (1) providers serving children in need of mental or behavioral health care and (2) beds available to the children through these providers, programs, and facilities.

EFFECTIVE DATE: July 1, 2022

§ 80 — GRANTS TO YOUTH SERVICE BUREAUS AND MUNICIPAL JUVENILE REVIEW BOARDS

Requires DCF to provide grants to youth service bureaus and municipal juvenile review boards to address truancy and chronic absenteeism in schools

For FY 23 and each subsequent fiscal year, the bill requires DCF to provide grants to youth service bureaus and municipal juvenile review boards to address truancy and chronic absenteeism in schools by supporting prosocial activities, family engagement services, credible messenger engagement, and care coordination for repeat juvenile offenders.

Under the bill, a grant recipient may coordinate the delivery of service with a state agency, local or regional board of education, or community-based organization. DCF must determine how grants are to be distributed and prioritize any youth service bureau or juvenile review board located in a priority school district (as defined in state law).

EFFECTIVE DATE: July 1, 2022

§§ 82 & 83 — APPROPRIATIONS TO DPH

Appropriates an unspecified amount to DPH in FY 23 to increase the number of child psychiatry medical residencies and fellowships at in-state hospitals; appropriates $150,000 to DPH in FY 23 for a grant to an in-state children's hospital for coordinating a mental and behavioral health training and consultation program, and requires the hospital to report on the program

The bill makes two General Fund appropriations to DPH in FY 23.

First, it appropriates an unspecified amount to increase the number of child psychiatry medical residencies and fellowships at in-state hospitals.

Second, it appropriates $150,000 for a grant to an in-state children's hospital to coordinate a mental and behavioral health training and consultation program from January 1, 2023, to January 1, 2025. The program must be available to all in-state practicing pediatricians to help them gain the necessary knowledge, experience, and confidence to

effectively treat pediatric mental and behavioral health issues.

Under the bill, the hospital receiving this grant must annually report to the Public Health Committee on the program, starting by January 1, 2023, with the last report due January 1, 2025. The reports must address the hospital's program coordination, the number of participating pediatricians, the program's outcome, and any other information the hospital deems relevant.

EFFECTIVE DATE: July 1, 2022

§ 84 — STATEWIDE YOUTH MENTORING ORGANIZATION FUNDING

Allocates an unspecified sum of money for FY 23 to DCF from federal American Rescue Plan Act money to fund statewide youth mentoring organizations

The bill allocates an unspecified sum of money, for FY 23, to DCF from the federal funds the state received under the American Rescue Plan Act of 2021 (P.L. 117-2) to fund statewide youth mentoring organizations.

Under the bill, any organization receiving funds must annually report to DCF and the Children's Committee on how the funds are spent.

EFFECTIVE DATE: Upon passage

§ 89 — APPROPRIATION TO THE DEPARTMENT OF CORRECTION

Appropriates an unspecified amount to the Department of Correction (DOC) to provide mental and behavioral health services to children at juvenile detention facilities and correctional institutions

The bill appropriates an unspecified amount from the General Fund to DOC for FY 23. This appropriation is for providing mental and behavioral health services to children at juvenile detention facilities and correctional institutions, including the Manson Youth Institution and York Correctional Institution.

EFFECTIVE DATE: Upon passage

COMMENT

Student Loan Consolidation by CHESLA

Under Section 45 of the bill, CHESLA must administer a loan forgiveness program under which it must consolidate applicants' federal and state loans. However, the authority to consolidate student loans made under federal programs rests solely with the U.S. Department of Education (20 U.S.C. § 1087i-2; 34 C.F.R. § 685.220). State law gives CHESLA the authority to refinance federal and private student loans (CGS § 10a-179(a)). It does not have authority to consolidate student loans.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 28 Nay 1 (03/25/2022)