

OFFICE OF LEGISLATIVE RESEARCH
PUBLIC ACT SUMMARY



PA 22-81—sSB 2
Committee on Children
Appropriations Committee

AN ACT EXPANDING PRESCHOOL AND MENTAL AND BEHAVIORAL SERVICES FOR CHILDREN

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§ 1 — DEPARTMENT OF MENTAL HEALTH SERVICES (DMHAS) MOBILE CRISIS RESPONSE SERVICES

Requires DMHAS to make mobile crisis response services available to the public 24 hours a day, seven days a week

The act requires, for FY 23 and each year after, the Department of Mental Health and Addiction Services (DMHAS) to make mobile crisis response services available to the public 24 hours a day, seven days a week.

EFFECTIVE DATE: July 1, 2022

§ 2 — SOCIAL DETERMINANTS OF MENTAL HEALTH FUND

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Establishes a “Social Determinants of Mental Health Fund” and requires DCF commissioner to use the funds to help families with the costs of mental health services and treatment for their children

The act creates a “Social Determinants of Mental Health Fund” as a separate, nonlapsing General Fund account that must contain any money the law requires to be deposited into it. The Department of Children and Families (DCF) commissioner (1) must use the funds to make grants to families to help them cover the cost of mental health services and treatment for their children and (2) may accept federal funds or private grants or gifts to do so.

The act also requires the commissioner to set eligibility criteria for families to receive assistance based on social determinants of mental health, with the goal of reducing racial, ethnic, gender, and socioeconomic mental health disparities.

Under the act, social determinants of mental health include discrimination and social exclusion, adverse early life experiences, low educational attainment, poor educational quality and educational inequality, poverty, income inequality and living in socioeconomically deprived neighborhoods, food insecurity, unemployment, underemployment and job insecurity, poor housing quality and housing instability, impact of climate change, adverse features of the structures and systems in which persons live or work, and poor access to health care.

EFFECTIVE DATE: July 1, 2022

§§ 3 & 4 — MENTAL HEALTH PLAN FOR STUDENT ATHLETES

Requires SDE to establish, and boards of education to implement, a mental health plan for student athletes to raise awareness about available resources

Under the act, the State Department of Education (SDE) must establish a mental health plan for student athletes in collaboration with the intramural and interscholastic athletics governing authority. (A local or regional board of education governs its own intramural athletics. The Connecticut Interscholastic Athletics Conference, a private nonprofit organization, governs high school interscholastic athletics.)

The plan must be made available to local and regional boards of education to raise awareness about available mental health resources for student athletes, and all boards of education must implement it annually, starting with the 2023-24 school year. SDE must also post the plan on its website and provide technical assistance to boards of education implementing it.

The plan must cover:

1. access to the school district’s mental health services team;
2. screening and recognizing appropriate referrals for student athletes;
3. communication among mental health services team members;
4. management of student athlete medication administration;
5. crisis intervention services;
6. mitigation of student athletes’ risk; and
7. transition care for student athletes leaving athletics due to graduation, dismissal, or suspension.

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EFFECTIVE DATE: July 1, 2022

§ 5 — PIPELINE FOR CONNECTICUT'S FUTURE PROGRAM

Requires SDE, collaborating with DOL, to administer the Pipeline for Connecticut's Future Program

Prior law allowed local or regional boards of education to set up a “Pipeline for Connecticut’s Future” program with local businesses to create onsite student training opportunities for course credit. The act instead requires SDE, in collaboration with the Department of Labor (DOL), to administer this program.

Under the act, SDE must help boards of education enhance existing partnerships or make new ones with child care providers and early childhood education programs, as well as partnerships with more fields, such as manufacturing, computer programming, or culinary arts, and one or more local businesses, to offer a pathways program. This program must:

1. help students obtain occupational licenses, participate in apprenticeship opportunities, and gain immediate job skills;
2. provide industry-specific class time and cooperative work placements, onsite and apprenticeship training, and course credit and occupational licenses to students upon completion; and
3. be a pathways program in early child care, education, or mental health services and any additional fields that may lead to a diploma, credential, certificate, or license upon graduation, such as manufacturing, computer programming, or the culinary arts.

Additionally, SDE must provide incentives to boards of education for establishing these partnerships.

EFFECTIVE DATE: July 1, 2022

§ 6 — UCONN STUDY – K-12 SOCIAL MEDIA AND TELEPHONE IMPACT

Requires UConn to study the impact of social media and mobile telephone use on the mental health of K-12 students and report findings and recommendations to the Children and Public Health committees

The act requires UConn’s Neag School of Education to (1) study and evaluate the impact of social media and mobile telephone use on a student’s mental health from kindergarten through grade 12 and (2) by January 1, 2024, report its findings and any recommendations to the Children and Public Health committees.

Under the act, the study must include how this usage impacts the student’s educational experience and the school’s climate.

EFFECTIVE DATE: July 1, 2022

§ 7 — FAMILY CHILD CARE HOME STAFFING AND ENROLLMENT

Changes family child care home staffing and enrollment requirements

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Under prior law, a family child care home could care for up to six children, including the provider's own children who are not in school full time, plus three more children during the regular school year who are in school full time. However, if the provider has more than three children who are in school full time, then all of the provider's children could attend.

The act maintains the base maximum number of enrolled children at six throughout the year, including the provider's own children who are not enrolled in school full time, in situations where the provider does not employ an OEC-approved assistant or substitute. But if an assistant or substitute is employed, the act allows for up to nine children to be cared for, even if none of the children attend school full time.

By law, unchanged by the act, during the summer months when school is not in session, if the family child care home provider employs an OEC-approved assistant or substitute staff member, then the provider may care for up to three additional school-aged children. Under the law, (1) an assistant or substitute staff member is not required if all the additional school-age children are the provider's own children and (2) if the provider has more than three school-age children, all of them may attend during the summer months, even if this means more than three additional school-age children are attending.

EFFECTIVE DATE: July 1, 2022

§ 8 — FAMILY CARE COORDINATORS

Requires local and regional boards of education to hire or designate a family care coordinator

Each school year, starting with the 2022-23 school year, the act requires each local and regional board of education to hire or designate an existing employee to serve as the district's family care coordinator. The family care coordinator must work with school social workers, school psychologists, and school counselors under the board's jurisdiction and serve as the school system's liaison with mental health service providers to (1) provide students with access to mental health resources in the community and (2) bring mental health services to students in school.

EFFECTIVE DATE: July 1, 2022

§ 9 — WITHHOLDING RECESS AS A FORM OF STUDENT DISCIPLINE

Requires local and regional boards of education to adopt policies addressing the withholding of recess as a form of student discipline and specifies requirements and limitations for these policies

For each school year, starting with the 2022-23 school year, the act requires each local and regional board of education to adopt a policy it deems appropriate concerning the circumstances when, as a form of discipline, a school employee may prevent or otherwise restrict a student from participating in the entire time devoted to physical exercise (i.e., recess) in the regular school day.

Under the act, the policy must allow school employees to prevent or restrict recess when:

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1. a student poses a danger to the health or safety of other students or school personnel or
2. it is limited to the shorter recess period if there are two or more recess periods in the school day, so long as the student is allowed to participate in at least 20 minutes of physical activity during the school day.

The policy may allow recess prevention or restriction only once during a school week unless the student is a danger to the health or safety of other students or school personnel.

Additionally, the policy must not (1) include provisions that are unreasonably restrictive or punitive, as determined by the board, or (2) allow recess prevention or restriction if a student does not complete their work on time or for the student's academic performance.

Under the act, the recess policy must also distinguish between discipline that:

1. is imposed before recess begins and discipline imposed during recess and
2. (a) prevents or otherwise restricts a student from participating in recess before recess and (b) uses methods to redirect a student's behavior during recess.

The act also eliminates a more general provision requiring that the local and regional boards of education develop a recess policy by October 1, 2019, on school employees preventing students from participating in recess as a form a discipline. It also makes conforming changes.

EFFECTIVE DATE: Upon passage

§§ 10 & 11 — CHILDREN'S MENTAL HEALTH DAY

Requires (1) the governor to proclaim May 26 of each year to be "Get Outside and Play for Children's Mental Health Day" and (2) SDE to provide annual notice about the day to school boards starting with the 2022-2023 school year

The act requires the governor to proclaim May 26 of each year to be "Get Outside and Play for Children's Mental Health Day" to raise awareness about children's mental health and the positive effect that being outdoors has on children's mental health and wellness. Under the act, suitable exercises must be held in the State Capitol and in the public schools on that day or, if that day is not a school day, on the previous school day or on any day the local or regional school board prescribes.

The act also requires the SDE, starting with the 2022-2023 school year, to provide annual notice to local and regional school boards about the designated day, including any suggestions or materials for suitable exercises that may be held to observe it.

EFFECTIVE DATE: October 1, 2022, except the SDE notice requirement is effective July 1, 2022.

§ 12 — PAYMENT TO EARLY INTERVENTION SERVICES PROVIDERS

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For FYs 23 & 24, requires the OEC commissioner to make a \$200 general administrative payment to early intervention service providers for each child with an individualized family service plan that accounts for less than nine service hours during the acting month

For FYs 23 & 24, the act requires the OEC commissioner to make a \$200 general administrative payment to early intervention service providers for each child (1) with an individualized family service plan on the first day of the acting month and (2) whose plan accounts for less than nine service hours during the acting month, as long as the provider delivers at least one service during the month.
EFFECTIVE DATE: July 1, 2022

§ 13 — CHILD CARE CENTER TAX ABATEMENT

Authorizes municipalities to establish a property tax abatement for certain properties used for child care centers, group child care homes, or family child care homes

The act authorizes municipalities to establish a property tax abatement for property or part of a property (1) used for operating a child care center, group child care home, or family child care home and (2) owned by the person, persons, association, organization, corporation, institution, or agency holding the child care license. Under the act, municipalities may abate up to 100% of property taxes due on the property for up to five tax years.

Municipalities may establish the tax abatement by vote of their legislative bodies, or board of selectmen where the town meeting is the legislative body.
EFFECTIVE DATE: October 1, 2022, and applicable to assessment years beginning on or after that date.

§§ 14 & 15 — OEC REGULATIONS ON PARENTAL NOTIFICATION

Requires the OEC commissioner to adopt regulations requiring child care facilities to notify parents about certain incidents resulting in a child's injury or illness

The act requires the OEC commissioner to adopt regulations requiring child care centers, group child care homes, and family child care homes to (1) immediately notify an enrolled child's parent or guardian if the child exhibits or develops an illness or is injured while in the care of the center or home and (2) create a specific written record of the illness or injury. Under the act, "illness" means fever, vomiting, diarrhea, rash, headache, persistent coughing, persistent crying, or any other condition the OEC commissioner deems an illness.

The written record must include:

1. a description of the illness or injury;
2. the date, time, and location of the incident;
3. any action an employee takes in response; and
4. whether the child was transported to an emergency room, a doctor's office, or other medical facility because of the illness or injury.

Under the act, OEC's regulations must require child care centers, group child care homes, and family child care homes to:

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1. provide the written record of an illness or injury to the child's parent or guardian by the next business day;
 2. keep the written record for at least two years, and make it available immediately upon OEC's request; and
 3. maintain any video recordings created at the center or home for at least 30 days and make them immediately available upon OEC's request. It also makes conforming changes.
- EFFECTIVE DATE: July 1, 2022

§ 16 — DCF COST OFFSET AND BENEFIT PAYMENT POLICY

Prohibits DCF from using a child's Social Security disability benefits to offset the cost of their care while in DCF care and custody, and requires the DCF commissioner to establish a policy to manage these benefits

The act prohibits DCF from using Social Security disability benefits received by a child or youth in DCF care and custody to offset the cost of the child's care.

The act also requires the DCF commissioner, by January 1, 2023, to establish a policy on the management and expenditure of Social Security disability insurance benefit payments received by, or on behalf of, children and youths in the department's care and custody. Under the act, the policy must require (1) benefit payments to be deposited into a trust account maintained to receive such deposits and (2) records to be maintained concerning the total sum and remaining balance of payments deposited on each child or youth's behalf. The policy must also include guidelines on the management and oversight of each account and permissible and impermissible withdrawals from the account by children or youths or their guardians.

The act allows DCF to employ personnel to implement the above provisions.
EFFECTIVE DATE: July 1, 2022

§ 17 — DPH PILOT GRANT PROGRAM EXPANDING BEHAVIORAL HEALTH CARE FOR CHILDREN BY PEDIATRIC CARE PROVIDERS

Requires DPH, in consultation with DSS, to establish a pilot program to expand behavioral health care services to children by pediatric care providers in private practices

By July 1, 2023, the act requires the Department of Public Health (DPH) commissioner, in consultation with the Department of Social Services (DSS) commissioner, to establish a pilot grant program to expand behavioral health care offered to children by pediatric care providers in private practices.

Under the act, the DPH commissioner must establish the program, within available appropriations, to provide eligible providers a 50% match for the salaries of licensed social workers. Under the program, these social workers provide counseling and other services to children receiving primary health care from the providers. Additionally, the commissioner must (1) prescribe forms and criteria for the providers to apply and qualify for grant funds and (2) require the providers to report on how they use the funds to expand behavioral health care for children.

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EFFECTIVE DATE: July 1, 2022

§§ 18-20 — SAFE STORAGE OF PRESCRIPTION DRUGS AND CANNABIS

Requires DCP to develop documents on the safe storage and disposal of opioid drugs and cannabis and cannabis products and post the documents online; requires pharmacies, cannabis retailers, and hybrid retailers to post notices about these documents on their premises

The act requires the Department of Consumer Protection (DCP), by December 1, 2022, to develop documents on consumers' safe storage and disposal of opioid drugs, cannabis, and cannabis products that include information on best practices for (1) safely storing these drugs, cannabis, and products in a way that makes them inaccessible to children and (2) disposing of the unused and expired ones.

The act also requires the DCP commissioner to post the documents on the DCP website by December 15, 2022.

Additionally, the act requires pharmacies, cannabis retailers, and hybrid retailers, by January 1, 2023, to post a sign in a conspicuous place on their premises notifying consumers that they may visit DCP's website for information on safe storage and disposal.

EFFECTIVE DATE: July 1, 2022

§ 21 — HOSPICE DISPOSAL OF CONTROLLED SUBSTANCE

Requires certain hospice and hospice care programs to dispose of any unconsumed (presumably) controlled substance they dispensed or administered to a terminally ill person

The act requires licensed hospice and hospice care programs that provide hospice home care services for terminally ill people to dispose any controlled substance that they dispensed or administered to a terminally ill person. They must do so as soon as practicable after the person's death in a way that complies with (1) existing law's requirements for disposing controlled substances by home health care agencies and (2) any other applicable state and federal laws.

Under the act, a "controlled substance" is a drug, substance, or immediate precursor in schedules I to V of Connecticut's controlled substance scheduling regulations. The term does not include alcohol, nicotine, or caffeine.

Background — Controlled Substance Disposal Protocol

Under existing law, a DPH-licensed registered nurse at a home health care agency may, with the permission of the patient's designated representative, oversee the destruction and disposal of a patient's controlled substances, using DCP's recommendations on how to do so. The registered nurse must maintain written or electronic documentation for three years on a form prescribed by DCP, which must be maintained with the patient's medical record. Under the law, the registered nurse and the patient's designated representative must not be prevented from depositing the patient's controlled substances in a statutorily authorized prescription drug drop box (CGS § 21a-262).

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EFFECTIVE DATE: October 1, 2022

§ 22 — CHILD CARE TAX CREDIT STUDY

Requires DRS to conduct a study to identify options for establishing a personal income tax credit for taxpayers with dependent children enrolled in child care

The act requires the Department of Revenue Services (DRS) commissioner to conduct a study to identify options for establishing a personal income tax credit for taxpayers with dependent children enrolled in child care. The commissioner must report on the study's findings and any recommendations to the Children's Committee by January 1, 2023.

EFFECTIVE DATE: Upon passage

§ 23 — OUT-OF-POCKET MEDICAL COSTS FOR CHILD CARE FACILITY EMPLOYEES

Requires DSS, in consultation with the State Comptroller, to conduct a study to identify ways the state can financially assist child care facility employees with out-of-pocket medical costs

The act requires the DSS commissioner, in consultation with the state comptroller, to study ways the state can provide financial assistance to child care facility employees for out-of-pocket medical costs.

By January 1, 2024, the commissioner must report to the Children's Committee on the study's findings, which must include an analysis of whether child care facility employees are eligible to participate in any state employee health insurance plan under development and any legislative recommendations.

EFFECTIVE DATE: Upon passage

§ 24 — TASK FORCE TO STUDY CHILDREN'S NEEDS

Reconvenes a 25-member task force to continue to study the (1) comprehensive needs of children in the state and (2) extent to which educators, community members, and local and state agencies are meeting them

PA 21-46 (§ 30) established a 25-member task force to study the (1) comprehensive needs of children in the state and (2) extent to which the needs are being met by educators, community members, and local and state agencies. The task force submitted its findings to the Children's Committee in December of 2021 and terminated on January 1, 2022.

Task Force Reconvened

The act reconvenes the task force to continue to study children's needs and tasks them with the same responsibilities as before, and also requires them to make recommendations to meet the demand for infant and toddler care in the state by (1) increasing access to and enrollment in child care centers, group child care homes,

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and family child care homes; and (2) identifying resources to help child care facilities meet demand.

The act also requires the task force to study the feasibility of adjusting school start times to improve students' mental and physical well-being.

As under PA 21-46 (§ 30), the act requires the task force to:

1. identify children's needs using certain principles of the whole child initiative developed by the Association for Supervision and Curriculum Development;
2. recommend new programs or changes to programs run by educators or local or state agencies to better address children's needs;
3. recognize any exceptional efforts to meet the comprehensive needs of children by educators, local or state agencies, and community members (i.e., any person or private organization that provides services or programs for children);
4. identify and advocate for funds and other resources required to meet the needs of children in the state;
5. identify redundancies in existing services or programs for children and advocate for cutting them; and
6. assess all publicly available data on the identified needs and collect, or make recommendations for the state to collect, any data that is not being collected by educators, community members, or local or state agencies.

Membership and Appointing Authorities

The act requires the task force to consist of the following members appointed under PA 21-46 (§ 30):

1. an educator employed by a local or regional board of education and a licensed social worker working with children, both appointed by the House speaker;
2. a representative of the board of directors of the Association for Supervision and Curriculum Development affiliate in the state and a representative of a higher education institution in the state, both appointed by the Senate president pro tempore;
3. a school administrator employed by a local or regional board of education, appointed by the House majority leader;
4. a chairperson of a local or regional board of education, appointed by the Senate majority leader;
5. a director or employee of a private nonprofit organization in the state that provides services or programs for children, appointed by the House minority leader;
6. a director or employee of a private nonprofit organization in the state that provides health-related services or programs for children, appointed by the Senate minority leader;
7. the agriculture, children and families, developmental services, early childhood, economic and community development, education, housing,

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- labor, mental health and addiction services, public health, social services, and transportation commissioners or their designees;
8. the healthcare advocate or his designee;
 9. the Commission on Human Rights and Opportunities executive director or her designee;
 10. the Technical Education and Career System superintendent or his designee;
 11. the chief court administrator or his designee; and
 12. the director of Special Education Equity for Kids of Connecticut or the director's designee.

Under the act, if any member declines an appointment the appointing authority must select a new appointee and legislators may be appointed to the taskforce. All initial appointments must be made by June 23, 2022. The appointing authority must fill any vacancy within 30 days. Task force chairpersons may fill a vacancy if it is not filled by the appointing authority.

The House speaker and the Senate president pro tempore must select the chairpersons of the task force from among its members. The chairpersons must schedule and hold the task force's first meeting by July 23, 2022.

The Children's Committee administrative staff must serve as administrative staff of the task force.

Reporting Requirements

The act requires the task force to update the report under PA 21-46 (§ 30) twice and submit it and any additional findings and recommendations to the Children's Committee by January 1, 2023, and January 1, 2024. The task force terminates on the date that it submits the report or January 1, 2024, whichever is later.

EFFECTIVE DATE: Upon passage

§ 25 — MEDICAID STATE PLAN EXPANSION

Expands the Medicaid state plan to include services provided by certain associate licensed behavioral health clinicians under an enrolled independent licensed behavioral health clinician's supervision

The act requires the DSS commissioner, by October 1, 2022, to provide Medicaid payments to an enrolled, independent, licensed behavioral health clinician in private practice for covered services performed by an associate licensed behavioral health clinician under the independent clinician's supervision. This requirement applies if the (1) associate clinician is working within his or her scope of practice and (2) independent clinician is authorized under state law to supervise the associate clinician and complies with any supervision and documentation requirements required by law.

Under this provision an "independent licensed behavioral health clinician" is a licensed psychologist, marital and family therapist, clinical social worker, or professional counselor. An "associate licensed behavioral health clinician" is a licensed marital and family therapy associate, master social worker, or professional counselor associate. "Private practice" means a practice setting that does not require

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a facility or institutional license and includes both solo and group practices of independent licensed behavioral health clinicians.

The act specifies that its provisions do not alter any requirements applicable to these services, including scope of practice, supervision, and documentation requirements.

EFFECTIVE DATE: July 1, 2022

§ 26 — LICENSURE BY RECIPROCITY OR ENDORSEMENT FOR SPEECH AND LANGUAGE PATHOLOGISTS AND OCCUPATIONAL THERAPISTS

Requires DPH, in consultation with OEC, to develop and implement a plan to establish licensure by reciprocity or endorsement for speech and language pathologists and occupational therapists licensed in other states who intend to provide services under the Birth-to-Three program

The act requires the DPH commissioner, in consultation with the OEC commissioner, to develop and implement a plan to establish licensure by reciprocity or endorsement for speech and language pathologists and occupational therapists who are licensed or certified (or otherwise entitled to provide these services under a different designation) in other states.

For this licensure to apply, the:

1. other state must have requirements for practicing that are substantially similar to, or higher than, Connecticut's;
2. applicant must have no disciplinary history or pending unresolved complaints; and
3. applicant must intend to provide early intervention services by working for a participating program under the Birth-to-Three program.

When developing and implementing the plan, the DPH commissioner must consider eliminating barriers to the expedient licensure of these professionals, to immediately address the needs of children receiving Birth-to-Three early intervention services.

Under the act, any interstate licensure compact the state adopts on speech and language pathologists or occupational therapists supersedes the act's program for licensure by endorsement or reciprocity.

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

EFFECTIVE DATE: Upon passage

Background — Examination Waiver or Licensure by Endorsement Under Existing Law

Under existing law, for speech and language pathologists, DPH may waive the written examination requirement for licensure if the applicant (1) is licensed in another U.S. state or territory with licensing requirements at least equivalent to Connecticut's or (2) holds a certificate from an approved national organization (CGS § 20-411(b)). For occupational therapists, DPH may grant a license by endorsement to an applicant who (1) is licensed or certified in another state or

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jurisdiction (or entitled to perform similar services under a different designation) with practice requirements that are substantially similar to Connecticut's and (2) has no pending disciplinary action or unresolved complaints (CGS § 20-74c).

§ 27 — CONNECTICUT ALCOHOL AND DRUG POLICY COUNCIL

Adds the child advocate, or her designee, to the Connecticut Alcohol and Drug Policy Council within DMHAS

The act adds the child advocate, or her designee, to the Connecticut Alcohol and Drug Policy Council within DMHAS. By law, among other things, the council must (1) review policies and practices of state agencies and the judicial department on substance abuse treatment programs and prevention services, referral of people to these programs and services, and criminal justice sanctions and programs; and (2) develop and coordinate a state-wide, interagency, integrated plan for these programs and services and criminal sanctions.

EFFECTIVE DATE: July 1, 2022

§ 28 — DPH PRIMARY CARE DIRECT SERVICES PROGRAM

Requires community-based primary care services providers participating in DPH's direct service program to provide, or arrange access to, behavioral health services; makes certain mental health professionals eligible for the state loan repayment program; for FY 23, requires DPH to use at least \$1.6 million of the funds appropriated for the state loan repayment program for repayments for physicians

Existing law requires the DPH commissioner to establish, within available resources, a program to provide three-year grants to community-based primary care services providers to expand access to health care for the uninsured. The grants may be used for, among other things, (1) direct services; (2) loan repayment to primary care clinicians (e.g., family practice physicians); and (3) capital expenditures.

Community Based Primary Care Providers

Existing law requires the community-based primary care providers under the direct service program to provide, or arrange access to, certain health services (e.g., primary and preventive services). The act requires them to also provide, or arrange access to, behavioral health services.

Primary Care Clinicians

The act makes psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists, and licensed professional counselors eligible for the state loan repayment program. It does so by broadening the program's definition of "primary care clinicians" to include these professional designations. Under existing law, "primary care clinicians" also include family practice physicians, general practice osteopaths, obstetricians and gynecologists, internal medicine physicians, pediatricians, dentists, certified nurse midwives,

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advanced practice registered nurses, physician assistants, and dental hygienists.

State Loan Repayment Program

Under the act, for FY 23, DPH must spend at least \$1.6 million of the funds appropriated for the state loan repayment program for repayments for qualifying physicians. It may spend any remaining funds for other health care providers.

Under the act, a qualifying "physician" is any state licensed physician who (1) graduated from a Connecticut medical school or completed his or her medical residency program at a Connecticut licensed hospital and (2) is employed as a physician in the state.

Under existing law, funds appropriated for the state loan repayment program do not lapse until 15 months after the end of the fiscal year for which they were appropriated.

EFFECTIVE DATE: Upon passage

§ 29 — PHYSICIAN RECRUITMENT WORKING GROUP

Requires the DPH commissioner to convene a working group to advise her on ways to enhance physician recruitment in the state

The act requires the DPH commissioner, by January 1, 2023, to convene a working group to advise her on ways to enhance physician recruitment in the state. The group must report its findings to the commissioner and the Public Health Committee by January 1, 2024.

The working group must examine at least the following issues:

1. recruiting, retaining, and compensating primary care, psychiatric, and behavioral health care providers;
2. the potential effectiveness of student loan forgiveness;
3. barriers to recruiting and retaining physicians due to non-compete clauses;
4. access to health care providers and any effect of the health insurance landscape on limiting health care access;
5. barriers to physicians participating in health care networks; and
6. assistance for graduate medical education training.

The working group must include at least the following 14 members, as shown in the table below.

Physician Recruitment Working Group Required Membership

One representative each from an in-state hospital association, in-state medical society, and a regional physician recruiter association
Two state-licensed physicians: <ul style="list-style-type: none"> • one from a small group practice (i.e., less than eight full-time equivalent physicians) • one from a multisite group practice (i.e., a group with over 100 full-time equivalent physicians practicing across the state)

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One representative each from at least three different medical schools
The human resources director of at least one in-state hospital
One member of a patient advocacy group
Four public members

The act requires the group to elect chairpersons from among its members.
EFFECTIVE DATE: July 1, 2022

§§ 30, 32 & 33 — OUT-OF-STATE TELEHEALTH PROVIDERS

Extends PA 21-9's provisions allowing certain out-of-state telehealth providers to provide telehealth services in Connecticut to June 30, 2024; starting July 1, 2024, authorizes certain out-of-state mental and behavioral health service providers to practice telehealth in Connecticut under certain conditions

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 act extends this authorization by one year until June 30, 2024. As under PA 21-9, the act 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 act 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 act does not extend this requirement to mental and behavioral health providers below.)

Mental and Behavioral Health Providers

Starting July 1, 2024, the act 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,

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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. provides telehealth services under a relevant Department of Public Health (DPH) order (see below);
3. provides mental or behavioral health services within his or her professional scope of practice and professional standards of care; and
4. maintains professional liability insurance or other indemnity against professional malpractice liability in an amount that at least equals what is required in Connecticut for these providers.

The act correspondingly permits the DPH commissioner to issue an order authorizing out-of-state telehealth providers to practice in Connecticut that may do the following:

1. limit the duration of this practice or the types of authorized telehealth providers allowed to do so and
2. impose conditions, including requiring out-of-state telehealth providers to apply for licensure, certification, or registration, as applicable.

Under the act, the commissioner may suspend or revoke an out-of-state telehealth provider's authorization to practice in Connecticut if he or she violates any condition the commissioner imposes or any applicable statutory requirements.

The act specifies that an order the commissioner issues authorizing out-of-state telehealth providers to practice in Connecticut is not a regulation under the Uniform Administrative Procedure Act.

EFFECTIVE DATE: Upon passage, except the provision on DPH orders authorizing out-of-state providers to practice telehealth in Connecticut takes effect July 1, 2022.

Background — Authorized Telehealth Providers

Under PA 21-9 and the act, 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.

§ 31 — HOSPITAL FACILITY FEES FOR TELEHEALTH SERVICES

Prohibits hospitals from charging a facility fee for telehealth services, whether those services are provided on or off the hospital campus

The act prohibits hospitals from charging facility fees for telehealth services, whether those services are provided on or off the hospital campus. (Existing law prohibits telehealth providers from charging facility fees.)

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By law, a “facility fee” is a fee a hospital charges for bills for outpatient services provided in a hospital-based facility to compensate the hospital for its operational expenses. It is separate and distinct from a professional fee for medical services (CGS § 19a-508c).

EFFECTIVE DATE: Upon passage

§§ 32, 34 & 38 — TEMPORARY EXPANSION OF TELEHEALTH SERVICE DELIVERY REQUIREMENTS

Extends PA 21-9’s temporary expanded telehealth requirements for delivering telehealth services by one year to June 30, 2024, and makes minor and technical changes

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. The act extends the more expansive requirements described below by one year until June 30, 2024, and applies them to all authorized telehealth providers, instead of only in-network and CMAP telehealth providers.

The act 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 prior law, they may do so despite existing laws, regulations, policies, or procedures on medical marijuana certifications.

Audio-Only Telephone

The act allows authorized 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 act extends, until June 30, 2024, the requirement that the provider also determine whether the (1) patient has health coverage that is fully insured, not fully

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insured, or provided through CMAP and (2) coverage includes telehealth services. It also extends telehealth providers' authority 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.

The act extends, until June 30, 2024, the requirement that this includes information on the limited duration of the act's provisions. A patient's revocation of consent must also be documented in their medical record.

Use of Additional Communication Technologies

The act extends 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 act allows the use of these additional information and communication technologies until June 30, 2024.

Payment for Uninsured and Underinsured Patients

The act extends the requirement that a telehealth provider determine whether the patient has health coverage for the telehealth services provided. 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 the 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.

For the latter, if the plan uses a provider network, the act prohibits this amount from exceeding the in-network amount, regardless of the telehealth provider's network status.

As under PA 21-9, the act requires a telehealth provider who determines that a patient cannot pay for telehealth services to offer the patient financial assistance to the extent required under federal or state law.

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DPH Regulatory Requirements

Regardless of existing law, PA 21-9 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.

Under the act, she may do this until June 30, 2024, as she deems necessary to reduce the spread of COVID-19 and protect the public health.

EFFECTIVE DATE: Upon passage

§§ 35-37 — TEMPORARY INSURANCE COVERAGE REQUIREMENTS FOR TELEHEALTH SERVICES

Extends the temporarily expanded commercial insurance coverage requirements and prohibitions for telehealth services under PA 21-9 by one year to June 30, 2024; clarifies that telehealth excludes audio-only telephone for policies that use a provider network and the telehealth provider is out-of-network; applies the coverage requirements to high deductible health plans to the extent permitted by federal law

Extension of Temporarily Expanded Coverage Requirements

Existing law generally sets requirements and restrictions for health insurance coverage of telehealth services. PA 21-9 temporarily replaces these requirements with similar but more expansive requirements for telehealth coverage until June 30, 2023. This act extends the more expansive requirements until June 30, 2024.

Coverage Required

As in existing law and PA 21-9, the act 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. Insurers, HMOs, and related entities may conduct utilization reviews for telehealth services as they do for in-person services, including using the same clinical review criteria. (The act specifies that telehealth excludes audio-only telephone for policies that use a provider network and when the telehealth provider is out-of-network.)

Prohibitions

Under the act, as under PA 21-9, health insurance policies cannot exclude coverage (1) just because a service is provided through telehealth, so 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 act prohibits health carriers (e.g., insurers and HMOs),

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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 act 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 act 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, or similar, account, the act applies to the maximum extent permitted by federal law that does not affect the account's tax preferred status.

EFFECTIVE DATE: Upon passage

§§ 39 & 40 — PERMANENT INSURANCE COVERAGE REQUIREMENTS FOR TELEHEALTH SERVICES

Beginning July 1, 2024, requires commercial 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 (§§ 35-37), the act 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. Prior law required the coverage to the extent the service is covered in person by any provider.

The act 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

§ 41 — TELEHEALTH STUDY

Requires OHS to study telehealth services in the state

The act requires the Office of Health and Strategy (OHS) executive director to study the provision of, and coverage for, telehealth services in the state. The study

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must include (1) the feasibility and impact of expanding access to telehealth services, telehealth providers, and coverage for telehealth services in the state beginning July 1, 2024, and (2) any means available to reduce or eliminate obstacles to these services, including reducing patient costs.

The act requires the OHS executive director, by January 1, 2023, to report its findings to the Public Health, Human Services, and Insurance committees.

EFFECTIVE DATE: Upon passage

§ 42 — PSYCHOLOGY INTERJURISDICTIONAL COMPACT

Enters Connecticut into the Psychology Interjurisdictional Compact, which provides a process authorizing psychologists to practice by (1) telehealth and (2) temporary in-person, face-to-face services across state boundaries, without requiring psychologist licensure in each state

The act enters Connecticut into the Psychology Interjurisdictional Compact (PSYPACT). The compact creates a process authorizing psychologists to practice by (1) telehealth (unlimited) and (2) temporary in-person, face-to-face services (30 days per year per state) across state boundaries, without requiring psychologist licensure in each state. A psychologist can apply for authorization for either or both types of interjurisdictional practice under the compact.

Among various other provisions, the compact:

1. sets eligibility criteria for psychologists to practice under the compact;
2. is overseen by a commission of representatives from the participating states;
3. addresses several matters related to disciplinary actions for psychologists practicing under the compact, such as information sharing among participating states and automatic suspension of practice in some circumstances;
4. allows the commission to levy an annual assessment on participating states to cover the cost of its operations;
5. provides that amendments to the compact only take effect if all participating states adopt them into law; and
6. provides a process for states to withdraw from the compact.

A broad overview of the compact appears below.

EFFECTIVE DATE: October 1, 2022

Compact Overview

PSYPACT creates a process authorizing (1) telepsychology (i.e., telehealth) or (2) temporary in-person, face-to-face practice in other compact states, without requiring psychologist licensure in each of the states.

Under the compact, “telepsychology” is the provision of psychological services using telecommunication technologies. “Temporary in-person, face-to-face practice” is the practice of psychology by a psychologist who is physically present, not through telecommunications technologies, in another state for up to 30 days in a calendar year and based on notification to that state.

Under the compact, a “state” is a U.S. state, commonwealth, territory, or possession or the District of Columbia.

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A “home state” is a compact state where a psychologist is licensed. If a psychologist is licensed in multiple compact states: (1) for telepsychology, the home state is the compact state where the psychologist is physically present when delivering those services, and (2) for temporary in-person practice, the home state is any state where the psychologist is licensed and practicing under the compact.

A “receiving state” is a compact state where the client or patient is physically located when the telepsychological services are delivered. A “distant state” is the compact state where a psychologist is physically present to provide temporary in-person, face-to-face services.

Eligibility and Conditions of Practice (§ 42, Art. III-VI)

Under the compact, a home state’s license authorizes a psychologist to practice in a receiving state (for telepsychology) or distant state (for temporary in-person services) only if the compact state meets the following criteria:

1. requires the psychologist to hold an active E.Passport (for telepsychology) or Interjurisdictional Practice Certificate (IPC) (for temporary in-person services);
2. has a mechanism to receive and investigate complaints about licensed individuals;
3. notifies the commission (see below), in compliance with the compact’s terms, about any adverse action (generally, public disciplinary action) or significant investigatory information about a licensed individual;
4. requires an identity history summary (e.g., FBI data on arrests) of all applicants at initial licensure (including fingerprints or other biometric data checks), no later than 10 years after the compact’s activation; and
5. complies with the commission’s rules and bylaws.

To be eligible to practice interjurisdictional telepsychology or through temporary in-person services under the compact, a psychologist must hold an unrestricted license in a compact state and hold a graduate psychology degree.

The degree-granting higher education institution must meet specified accreditation or similar requirements (depending on whether it is a domestic or foreign school). The psychology program itself also must meet several requirements, such as (1) being clearly identified and labeled as a psychology program, (2) including a curriculum of at least three academic years of full-time graduate study for a doctorate, and (3) including an acceptable residency.

The psychologist also must meet the following criteria:

1. have no adverse action or criminal record history that violates the commission’s rules;
2. possess a current, active E.Passport (for telepsychology) or IPC (for temporary in-person practice);
3. provide attestations on specified matters (e.g., areas of intended practice) and an information release; and
4. meet other criteria as defined by commission rules.

Under the compact, “E.Passport” is the certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that promotes standardization in

interjurisdictional telepsychology practice criteria and facilitates the process for licensed psychologists to provide telepsychological services across state lines. The “IPC” is the certificate issued by the ASPPB that grants temporary authority to practice based on notification to the state psychology regulatory authority of intention to practice temporarily and verification of qualification for that practice.

Currently, many of the specific requirements for the E.Passport and IPC are similar. For example, both require the psychologist to have a current license based on a doctorate. Both the E.Passport and IPC require annual renewal; the former requires three hours of continuing education on the use of technology in psychology.

The compact also makes other rules for states to maintain authority over a psychologist practicing under the compact. For example, it provides that:

1. the home state maintains authority over the license of any psychologist practicing in a receiving state under the authority to practice interjurisdictional telepsychology;
2. a psychologist practicing in a distant state under the temporary authorization to practice is subject to that state’s authority and law; and
3. a psychologist practicing under the compact must do so within the scope of practice of the receiving or distant state (for telepsychology or temporary in-person practice, respectively).

For telepsychology under the compact, the psychologist also must (1) initiate the client or patient contact in a home state via telecommunications technologies and (2) comply with other commission rules.

Adverse Actions, Regulatory Board Authority, and Coordinated Licensure Information System (§ 42, Art. IV-V, VII-IX)

The compact addresses several matters related to investigating and disciplining psychologists practicing under its procedures, including the following examples:

1. a home state may discipline a psychologist licensed by that state, and a receiving or distant state may take adverse action on a psychologist’s authority to practice interjurisdictional telepsychology or temporary authorization to practice in that state under the compact;
2. if the home state or a receiving or distant state takes that action, the psychologist’s E.Passport or IPC is revoked;
3. a home state’s psychology regulatory authority must investigate and take appropriate action on reported inappropriate conduct in a receiving state as if the conduct happened in the home state and the home state’s law controls in determining any adverse action against the licensee;
4. a distant state’s psychology regulatory authority must investigate and take appropriate action on reported inappropriate conduct in that state as if the conduct happened in the home state, and the distant state’s law controls in determining any adverse action against the psychologist’s authorization to practice;
5. in addition to authority granted under state laws, psychology regulatory boards have specified authority under the compact, such as issuing cease

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- and desist or injunctive relief orders to revoke a psychologist's authority to practice interjurisdictional telepsychology or temporary authorization to practice;
6. psychologists cannot change their home state licensure during an investigation and home state regulatory authorities must promptly report the conclusion of investigations to the commission;
 7. the commission must develop a coordinated database for compact states to report and share information on disciplinary action against psychologists; and
 8. compact states must submit the same information on all licensees for inclusion in the database and the database administrator must promptly notify all compact states about any adverse action against, or significant investigative information on, any licensee in a compact state.

Psychology Interjurisdictional Compact Commission (§ 42, Art. X-XI)

The compact is administered by the Psychology Interjurisdictional Compact Commission, which consists of one voting member appointed by each compact state's psychology regulatory authority. The compact sets forth several powers, duties, and procedures for the commission. For example, the commission:

1. may promulgate rules to facilitate and coordinate the compact's implementation and administration (a rule has no effect if a majority of the compact states' legislatures reject it in the same way used to adopt the compact),
2. may levy and collect an annual assessment from each compact state and impose fees on other parties to cover the costs of its operations, and
3. must have its receipts and disbursements audited yearly and the audit report included in the commission's annual report.

The compact addresses several other matters regarding the commission and its operations, such as setting conditions under which its officers and employees are immune from civil liability.

Compact Oversight, Enforcement, Member Withdrawal, and Related Matters (§ 42, Art. XII-XIV)

Among other related provisions, the compact provides the following:

1. each compact state's executive, legislative, and judicial branches must enforce the compact and take necessary steps to carry out its purposes (§ 42, Art. XII(a));
2. the commission must take specified steps if a compact state defaults on its obligations under the compact, and after all other means of securing compliance have been exhausted, a defaulting state is terminated from the compact upon a majority vote of the compact states (§ 42, Art. XII(b));
3. upon a compact state's request, the commission must attempt to resolve a compact-related dispute among compact states or between compact and non-compact states (§ 42, Art. XII(c));

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4. the commission must enforce the compact and rules and may bring legal action against a compact state in default upon a majority vote of its commissioners (the case may be brought in the U.S. District Court in Georgia or the federal district where the commission's principal offices are located) (§ 42, Art. XII(d));
5. a compact state may withdraw from the compact by repealing that state's enabling legislation, but withdrawal does not take effect until six months after the repealing statute's enactment (§ 42, Art. XIII(c));
6. the compact states may amend the compact, but no amendment takes effect until all compact states enact it into law (§ 42, Art. XIII(e)); and
7. the compact's provisions must be liberally construed to carry out its purposes and if the compact is held to violate a compact state's constitution, it still remains in effect in the remaining compact states (§ 42, Art. XIV).

§ 43 — INTERSTATE MEDICAL LICENSURE COMPACT

Enters Connecticut into the Interstate Medical Licensure Compact, which provides an expedited licensure process for physicians seeking to practice in multiple states

The act enters Connecticut into the Interstate Medical Licensure Compact. The compact provides an expedited licensure process for physicians seeking to practice in multiple states, including by telehealth. Among other eligibility criteria, a physician must first be licensed in a member state and have never had his or her medical license subjected to disciplinary action. Eligible physicians can complete one application within the compact, but receive separate licenses from the states where they will practice.

Among various other provisions, the compact:

1. sets additional eligibility criteria for physicians to practice under the compact;
2. is overseen by a commission of representatives from the member states;
3. addresses several matters related to disciplinary actions for physicians practicing under the compact, such as information sharing among member states and automatic suspension of practice in some circumstances;
4. allows the commission to levy an annual assessment on member states to cover the cost of its operations;
5. provides that amendments to the compact only take effect if all member states adopt them into law; and
6. makes a process for states to withdraw from the compact.

A broad overview of the compact appears below.

EFFECTIVE DATE: October 1, 2022

Compact Overview

The Interstate Medical Licensure Compact provides an expedited licensure process for physicians seeking to practice in multiple states. The compact defines "expedited license" as a full and unrestricted medical license granted by a member state to an eligible physician through the process described in the compact. A

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“state” is a U.S. state, commonwealth, district, or territory.

Physician Eligibility and Application Process (§ 43(3)-(7))

To be eligible to receive an expedited license under the compact, a physician must meet the following criteria:

1. have graduated from an accredited medical school or school listed in the International Medical Education Directory;
2. passed each component of the U.S. Medical Licensing Examination or Comprehensive Osteopathic Medical Licensing Examination within three attempts (or predecessor examinations accepted by a state medical board);
3. successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association;
4. hold specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association’s Bureau of Osteopathic Specialists;
5. possess a full and unrestricted license to practice medicine issued by a member board;
6. have no criminal history (e.g., convictions, community supervision, or deferred dispositions) for any felony, gross misdemeanor, or crime of moral turpitude;
7. have no history of disciplinary history against his or her medical license (other than for nonpayment of fees);
8. have never had a controlled substance license or permit suspended or revoked by a state or the U.S. Drug Enforcement Administration; and
9. not be under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction.

For expedited licensure registration through the compact, a physician must also designate a compact member state as the state of principal license. The physician must select a state in which he or she has an unrestricted license to practice medicine and that is:

1. the state of the physician’s principal residence;
2. the state where at least 25% of the physician’s practice of medicine occurs;
3. the location of the physician’s employer; or
4. if no state qualifies under the above three criteria, the physician’s state of residence for federal income tax purposes.

A physician seeking licensure through the compact must apply for an expedited license with the member board (i.e., the state physician licensing board) of the physician’s selected state of principal license. The member board must then evaluate the physician’s eligibility and issue a letter of qualification, verifying or denying eligibility, to the Interstate Commission (see below). As part of this process, the member board must conduct a criminal background check.

After the physician’s eligibility is verified, the physician must complete the commission’s registration process to receive a license in a member state (including payment of applicable fees). The member board then issues an expedited license to

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the physician, authorizing the physician to practice in that state according to its applicable laws.

An expedited license is valid for a period consistent with the member state's licensure period. Physicians seeking to renew an expedited license must complete a renewal process with the commission, subject to certain eligibility requirements (e.g., applicable continuing education requirements). The commission collects renewal fees and distributes them to the applicable member board.

Disciplinary Action and Investigations (§ 43(8)-(10))

The compact addresses several matters related to investigating and disciplining physicians licensed through its procedures, including the following examples:

1. member boards must report to the commission any public action or complaint against a physician who has applied for or received an expedited license through the compact, and other disciplinary or investigatory information as described in commission rules;
2. member boards can participate with one another in joint investigations of physicians licensed by them, and subpoenas issued by a member state are enforceable in other member states;
3. if the physician's license is subject to revocation, suspension, or certain other disciplinary actions in the state of principal license, then all of that physician's licenses in other member states are automatically placed on that same status; and
4. if disciplinary action is taken against a physician by a member board not in the state of principal license, then any other member board may (a) impose the same or any lesser sanction that is consistent with that state's Medical Practice Act or (b) pursue separate disciplinary action under its Medical Practice Act (in some cases, a member board must suspend a license for 90 days to allow for an investigation).

Interstate Medical Licensure Compact Commission (§ 43(11)-(15))

The compact is administered by the Interstate Medical Licensure Compact Commission, which consists of two voting members appointed by each member state (representing the member boards). The compact sets forth several powers, duties, and procedures for the commission. For example, the commission:

1. promulgates rules that are binding to the extent and in the way provided for in the compact,
2. enforces compliance with compact provisions as well as the commission's rules and bylaws, and
3. reports annually to the legislatures and governors of member states about its activities during the prior year and any financial audit reports.

The commission (1) can levy an annual assessment on member states to cover the costs of its operations, based on a formula that the commission determines, and (2) is subject to a yearly financial audit.

The compact addresses several other matters regarding the commission and its

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operations, such as setting conditions under which its officers and employees are immune from civil liability.

Compact Oversight, Enforcement, Member Withdrawal, Dissolution, and Related Matters (§ 43(16)-(24))

Among several other related provisions, the compact provides the following:

1. each member state's executive, legislative, and judicial branches must enforce the compact and take necessary steps to carry out its purposes (§ 43(16));
2. the commission must enforce the compact and rules and may bring legal action against a state in default upon a majority vote of the commissioners (the case can be brought in the U.S. District Court for the District of Columbia or, at the commission's discretion, the federal district where the commission's principal offices are located) (§ 43(17));
3. the commission must take specified steps if a member state is in default and, after all other means of securing compliance have been exhausted, a defaulting state is terminated from the compact upon a majority vote of the commissioners (§ 43(18));
4. upon a member state's request, the commission must attempt to resolve a compact-related dispute between member states or member boards (§ 43(19));
5. the commission may propose compact amendments, but no amendment takes effect unless the member states enact it into law by unanimous consent (§ 43(20));
6. a member state may withdraw from the compact by repealing that state's enabling legislation, but withdrawal does not take effect until one year after the repealing statute's effective date (§ 43(21));
7. the compact dissolves when its membership is reduced to one state (§ 43(22));
8. the compact's provisions are severable and its provisions must be liberally construed to carry out its purposes (§ 43(23)); and
9. all member state laws in conflict with the compact are superseded to the extent of the conflict (unless a compact provision exceeds the constitutional limits imposed on a member state's legislature) (§ 43(24)).

§ 44 — OEC TECHNICAL ASSISTANCE AND BUSINESS CONSULTING SERVICES EMPLOYEES

Requires OEC, for FY 23, to hire two full-time employees to provide technical assistance and business consulting services for child care services providers

For FY 23, the act requires OEC to hire two full-time employees to provide technical assistance and business consulting services for child care services providers. Under the act, these providers include certain child care centers, group and family child care homes, and night-care and year-round programs.

EFFECTIVE DATE: July 1, 2022

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§ 45 — DCF GRANTS TO YOUTH SERVICE BUREAUS

For FY 23, requires the excess amount to be distributed proportionately among the YSBs, if the amount appropriated for grants to them in FY 23 is more than it was for FY 22

By law, DCF is responsible for administering the youth service bureau (YSB) grant and enhancement grant programs, within available appropriations. YSBs provide resources and community-based services and programs for children, youth, and their families.

Under the act, for FY 23, if the amount appropriated for grants payable to YSBs under this provision is more than the amount appropriated the grants for FY 22, the excess amount must be distributed proportionately among the YSBs.

EFFECTIVE DATE: July 1, 2022

§ 46 — OFFICE OF EMERGENCY MEDICAL SERVICES HEALTH PROGRAM ASSOCIATE

Requires DPH to hire a health program associate to administer mobile integrated health care programs for the Office of Emergency Medical Services

The act requires DPH, for FY 23, to hire a health program associate for the Office of Emergency Medical Services to administer mobile integrated health care programs.

Under existing law, the office is responsible for program development activities, including (1) public education and information programs, (2) administering the emergency medical services equipment and local system development grant program, (3) planning, (4) regional council oversight, and (5) training.

EFFECTIVE DATE: July 1, 2022