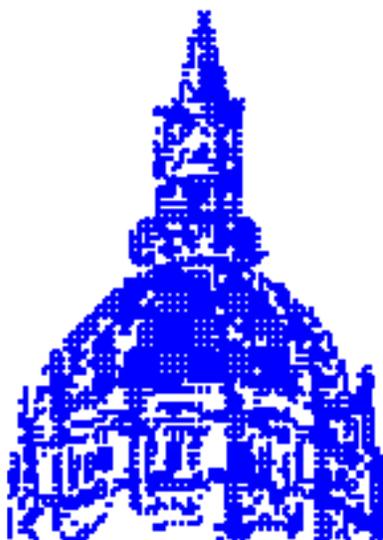


Office of Legislative Research
Connecticut General Assembly



CHILDREN



By:
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NOTICE TO READERS

This report provides brief highlights of public acts passed during the 2005 regular and special sessions.

Not all provisions of the acts are included; readers are encouraged to obtain the full text of acts that interest them from the Connecticut State Library, the House Clerk's office, or the General Assembly's website (<http://www.cga.state.ct.us/default.asp>). Complete summaries of all public acts passed in 2005 will be available in the fall when OLR's *Public Act Summary* book is published; some are now available on the OLR website (<http://www.cga.state.ct.us/olr/publicactsummaries.asp>)

All acts summarized here are effective October 1, 2005, unless otherwise noted.

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MINIMUM WAGE

This act increases the state's minimum hourly wage from \$7.10 to \$7.40 on January 1, 2006 and to \$7.65 on January 1, 2007.

(PA 05-32)

TRANSPORTATION

Mini-Motorcycles

This act prohibits someone from operating or riding as a passenger on a mini-motorcycle or, as the owner of such a vehicle, allowing someone to operate or ride as a passenger on one on any highway, public sidewalk, or public property in the state. It also prohibits operation on private property without the property owner's written permission.

The act requires anyone offering a mini-motorcycle for sale, lease, or rent to provide warning labels and advisories on the safe and legal use of such vehicles, the limitations on their use, and the possible consequences for violating the limitations.

(PA 05-173)

Child Restraints

This act (1) extends the requirement to use child restraint system use requirements from children under age four weighing less

than 40 pounds to children under age seven or who weigh less than 60 pounds, regardless of age (children being transported in student transportation are excepted from this requirement); (2) requires any child under age one or weighing less than 20 pounds to be transported in his child restraint system in a rearward-facing position; and (3) requires children restrained in booster seats to be anchored by a seat belt that includes a shoulder belt.

(PA 05-58)

Use of Mobile Phone While Driving

Except under certain circumstances, this act prohibits drivers operating under learners' permits or with licenses issued pursuant to requirements applicable to 16- or 17-year old license applicants from using any mobile telephone while the vehicle is moving, whether or not it has a hands-free accessory.

PA 05-220 subsequently amended the act to (1) expand its prohibitions to apply to the use of mobile electronic devices as well as mobile telephones; (2) eliminate exemptions from the hand-held mobile telephone prohibitions for drivers of taxicabs, tow trucks, or buses without passengers; and (3) make it clear that this act prohibits the use of any type of

mobile telephone by drivers under age 18, except in the emergency situations it defines.

(PA 05-159 and PA 05-220)

Training and Restrictions for 16- and 17-Year Old Drivers

This act increases, from eight to 20, the minimum hours of behind-the-wheel instruction 16- and 17-year olds learning to drive under learner's permits must have before they qualify for licensure. It also prohibits 16- or 17-year old licensed drivers, with some exceptions, from driving from 12:00 a.m. to 5:00 a.m. and creates an exception to driving hour and passenger restrictions for teenage drivers performing official emergency response duties for certain fire or emergency medical service organizations. Finally, it permits 16- and 17-year olds to transport more than one of their parents during the first three months they are licensed.

(PA 05-54)

DEPARTMENT OF CHILDREN AND FAMILIES

Reporting Child Abuse

This act increases, from 30 to 45 calendar days, the time the Department of Children and Families (DCF) has to complete child abuse and neglect investigations.

(PA 05-25)

Income Limits for Adults Caretakers of Children

This act increases the income limit for adult coverage in the HUSKY A program from 100% to 150% of the federal poverty level (FPL). HUSKY A (Medicaid) coverage is available to adults who are parents or caretaker relatives of children receiving HUSKY A. The income limit for the children is 185% of the FPL. The current FPL is \$19,350 for a four-person household.

(PA 05-280, effective July 1, 2005)

Psychiatric Inpatient Bed Capacity Study

This act requires the Office of Health Care Access (OHCA) commissioner to establish a committee to study whether there are enough inpatient psychiatric beds for children in the state and make recommendations to expand capacity. The committee consists of the DSS and DCF commissioners or their designees, the child advocate or her designee, and representatives of private children's hospitals and children's mental health advocacy groups. The OHCA commissioner must report the committee's findings and recommendations to the General Assembly by January 1, 2006.

(PA 05-280, effective July 1, 2005)

Behavioral Health Partnership Established

This act establishes a Behavioral Health Partnership between DCF and Department of Social Services (DSS) to develop and implement an integrated behavioral health system for children and families receiving services under HUSKY A and B; children enrolled in DCF's voluntary services program; and, at the DCF commissioner's discretion, other children and families the department serves. The Connecticut Community KidCare program, through which these agencies serve HUSKY A and B and voluntary services program participants, remains in place.

The partnership is designed to increase access to quality behavioral health services through (1) expanding individualized, family centered, community-based services and reducing unnecessary institutional and residential service use; (2) maximizing federal revenue and capturing and reinvesting any such revenue derived from reducing residential and increasing community-based services; (3) improving administrative oversight and efficiency; and (4) monitoring overall performance, individual outcomes, and provider performance (in the latter case taking client acuity mix into consideration).

The act also requires the agencies to follow specific

financial requirements concerning converting from grant-funded to rate-based services (see Rate Setting, below).

(PA 05-280, effective July 1, 2005)

Partnership Evaluation

The act requires DCF and DSS to evaluate the partnership annually beginning October 1, 2006. The evaluation must examine the partnership's provision of services, including the status of the ASO implementation and collaboration between the departments, the services provided, the number of people served, and program outcomes and spending for children and adults. They must submit the report to the Appropriations, Human Services, and Public Health committees.

The act also requires DCF to monitor the implementation of the partnership and report annually on any estimated cost savings that result from it. The report goes to the above committees.

Prior law required the agencies, within available appropriations, to conduct a five-year, independent longitudinal evaluation of the KidCare program's effectiveness.

(PA 05-280, effective July 1, 2005)

Agency Direction

This act requires the DSS and DCF commissioners to designate a partnership director in each agency. The director coordinates his or her agency's responsibilities for planning, developing, administering, and evaluating the activities the agency undertakes to meet the system's goal of increasing access to services.

The departments must jointly direct the administrative services organization (ASO) they select to develop a community system of care to (1) alleviate hospital emergency room overcrowding, (2) reduce unnecessary admissions to hospitals and residential treatment facilities and the length of time people stay there, and (3) increase the availability of outpatient services.

(PA 05-280, effective July 1, 2005)

Management of the KidCare Program

Prior law governing the KidCare program permitted the DSS commissioner to delegate to DCF responsibility for the clinical management portion of the agencies' contract with the ASO pertaining to children. This act removes the limitation that DCF's responsibility is solely for children, apparently giving DCF clinical management responsibility for any adults the partnership serves. It also allows

DSS to contract with an ASO to develop a provider network.

The prior law governing the KidCare program required the DSS and DCF commissioners jointly to develop clinical management policies and procedures for implementation by the ASO. It permitted the agencies to implement these while in the process of adopting them as regulations. The interim measures were to remain valid until the regulations took effect or December 1, 2003, whichever happened first. The act extends this deadline to the earlier of December 31, 2006 or the regulations' effective date.

(PA 05-280, effective July 1, 2005)

Behavioral Health Partnership Oversight Council

Responsibilities. The act creates a 38-member Behavioral Health Partnership Oversight Council to advise DSS and DCF on planning and implementing the partnership. The council must make recommendations on partnership planning and implementation matters, including its review of

1. the agencies' contract with the ASO to assure that its decisions are based solely on the clinical management criteria developed by the committee the bill establishes;
2. behavioral health services provided under HUSKY A

- and HUSKY B to assure that federal fund revenues are being maximized;
3. periodic reports on program activities, finances, and outcomes, including reports from the partnership director on achieving the system's goals;
 4. consumer grievance procedures, and
 5. proposed provider-specific rates for certain services.

The council can conduct an external, independent evaluation of the partnership or can have one done. Beginning March 1, 2006, it must report annually on its activities and progress to the Appropriations, Human Services, and Public Health committees.

Membership and

Procedures. The council consists of 29 voting and nine nonvoting members. The voting members are (1) the chairmen and ranking members of the Appropriations, Human Services, and Public Health committees; (2) a member of the Community Mental Health Strategy Board, selected by the board; the Department of Mental Health and Addiction Services (DMHAS) commissioner or his designee, and (4) 16 people selected as follows by the chairmen of the Medicaid Managed Care Advisory Council:

1. two general or psychiatric hospital representatives,
2. two parents of children with behavioral health problems or who have received child protection

- or juvenile justice services from DCF,
3. one adult with a psychiatric disability,
 4. one advocate for adults with psychiatric disabilities and one for children with behavioral health disorders,
 5. one person with expertise in health policy and evaluation,
 6. a primary care provider and a psychiatrist serving HUSKY children,
 7. an adult with a substance abuse disorder or an advocate for such adults,
 8. a representative of school-based health clinics,
 9. one adult and one children's community-based behavioral health services provider,
 10. a children's residential treatment service provider, and
 11. a member of the Medicaid Managed Care Advisory Council.

The council contains the following nine nonvoting, ex-officio members:

1. one each appointed by the DCF, DSS, and DMHAS commissioners and the Office of Policy and Management secretary to represent their respective agencies;
2. one ASO representative; and
3. a representative of each Medicaid managed care

organization (there are currently four).

All appointments must be made by July 1, 2005. The Medicaid Managed Care Advisory Council chairmen select the partnership advisory council chairmen who must convene the first meeting by August 1, 2005. The council must meet at least monthly. The Legislative Management Committee must provide the chairmen with administrative support and help in convening the council's meetings. The initial appointing authorities fill membership vacancies.

(PA 05-280, effective July 1, 2005)

Clinical Management

This act establishes a seven-member committee to develop clinical management guidelines the partnership and the ASO must use. The committee consists of two members each from DCF, DSS, and the oversight council and one member selected by the DMHAS commissioner. Their respective commissioners select the agency representatives; the council selects its representatives. All members must be expert or experienced in behavioral health services.

(PA 05-280, effective July 1, 2005)

Consumer Grievance Procedures

The act requires DCF and DSS to develop consumer grievance procedures. They must establish time frames, including an expedited review in emergencies, for people to appeal the ASO's decisions. The procedure must require that appeals be heard within 30 days after they are filed and decided within 45 days of filing. The oversight council must review and comment on the proposed procedures.

(PA 05-280, effective July 1, 2005)

Rate Setting

This act permits DSS and DCF to establish provider specific rates for inpatient, partial hospitalization, intensive outpatient, and other intensive services. If they do this before January 1, 2006, each provider's initial rates must at least equal its blend of rates under HUSKY A and B as of July 1, 2005. If they implement these rates after January 1, 2006, the initial rates must at least equal the blend of each provider's rates in effect 60 days before the date the partnership is implemented (which date the agencies apparently determine). The departments may provide grants, where necessary, to address the financial effects this new system may have on providers. The initial rate changes and the

grants must be made within available appropriations.

The departments can establish uniform outpatient rates that contain a differential payment for adult and child services. These cannot exceed the rates Medicare pays for these services.

The act's rate-setting provisions supersede other laws governing DSS rate-setting for hospitals, residential mental health and substance abuse facilities, and free-standing detoxification centers.

Before the partnership can convert any grant-funded services (the method DCF currently uses to pay service providers) to a rate-based, fee-for-service payment system, the bill requires DCF and DSS to submit documentation to the Oversight Council verifying that the proposed rates seek to cover the reasonable cost of providing the services.

The act requires the departments to submit initial rates, rate reductions, and changes in the methodology they use to establish rates to the Oversight Council for its review. If the council does not accept the rates or methodology changes, it can send its recommendations to the Appropriations, Human Services, and Public Health committees. These committees must hold a public hearing on the subject of the proposed rates (but not on rate-setting methodology) to learn the partnership's reasons for the

changes. They must make recommendations to the departments within 90 days after they submitted the changes to the council. The departments must make every effort to incorporate the council's and the committees' recommendations when setting rates.

(PA 05-280, effective July 1, 2005)

Agencies' Contract with ASO

This act requires DCF and DSS to contract jointly with one ASO to perform the following functions: eligibility verification; utilization, intensive care, and quality management; coordination of medical and behavioral health services; provider network development and management; recipient and provider services; and reporting. The contract must call for the ASO to begin performing these functions by October 1, 2005.

The act prohibits the ASO from having any financial incentive to approve, deny, or reduce services. It requires the ASO to base its decisions to authorize services solely on the clinical management guidelines set by the clinical management committee the act establishes. But, it allows the ASO to make exceptions to the guidelines when a member, a member's legal guardian, or a service provider asks and the ASO determines making an exception is in the member's best interest. The ASO must ensure that

service providers and people seeking services have timely (1) access to program information and (2) responses to inquiries, including those concerning clinical guidelines. DSS and DCF make decisions concerning guideline interpretation.

The ASO must provide or arrange for on-site service in hospitals to (1) help place children in appropriate settings as soon as practicable when it knows they have been in an emergency room for over 48 hours or (2) arrange discharge or appropriate placement as soon as practicable for children who have been hospital patients for more than five days longer than the ASO and hospital agree is medically necessary.

The act requires the partnership to establish policies to coordinate benefits for people who are covered by both the partnership and Medicaid managed care organizations. The policies must require coordinated delivery of behavioral and physical health care. They must be reviewed by the partnership oversight council.

(PA 05-280, effective upon passage)

Certifying Providers

This act authorizes the DCF commissioner to certify providers of early periodic screening, detection and treatment services, and rehabilitation service for purposes of Medicaid coverage. She can adopt regulations to do

this and can implement certification policies and procedures during that process by publishing notice of intent in the *Connecticut Law Journal*. These policies and procedures are effective until the regulations take effect.

(PA 05-280, effective July 1, 2005)

Eligibility for Subsidized Guardianship

This act makes relative guardians eligible, at the agency's discretion, for DCF's higher subsidized guardianship rate after they have cared for the child for six months. Prior law required them to have cared for the child for at least one year.

(PA 05-254)

VICTIMS OF YOUTHFUL OFFENDERS AND JUVENILE DELINQUENTS

Although youthful offender (YO) and juvenile delinquency proceedings are generally private, this act prohibits a judge from excluding victims from attending unless he finds good cause for doing so after hearing from the parties and the victim. Judges must clearly and specifically state their reasons on the record. It requires courts, in YO proceedings, to allow crime victims to make a statement before the court accepts a plea agreement or imposes a sentence based on a plea. It defines "victim" as the crime victim or his

parent or guardian, legal representative, or court-appointed victim advocate.

Lastly, the act absolves peace officers of liability for failing to comply with requirements under existing law to provide crime victims with certain information. Specifically, peace officers are not liable for failing to (1) present a card to crime victims that informs them of their rights and available services or (2) refer them to the Office of Victim Services for additional information about their rights and available services. Under existing law, "crime victims" are people who suffer direct or threatened physical, emotional, or financial harm as a result of a crime, including the immediate family of a minor, incompetent, or deceased victim or anyone designated by a deceased victim.

(PA 05-169)

MEMBERSHIP ON THE CHILD FATALITY REVIEW PANEL

This act increases, from seven to 13, the number of permanent Child Fatality Review Panel members by adding (1) the chief medical examiner; (2) an attorney, appointed by the Senate Minority leader; (3) a psychologist, appointed by the House majority leader; and (4) the commissioners of the departments of Children and Families, Public Health, and Public Safety, or their designees. It substitutes a social work professional (appointed by the

Senate minority leader) and an injury prevention representative (appointed by the House minority leader) for the former public child welfare practitioner and medical examiner slots, respectively.

It also increases, from two to three, the number of temporary experts or interested parties the panel can select and eliminates a requirement that these appointees review a specific death only.

The panel reviews and issues reports on unexplained or unexpected circumstances leading to the death of a child who has received services from state child welfare, social services, or juvenile justice agencies.

(PA 05-157, effective upon passage)

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