PA 22-47—sHB 5001
Public Health Committee
Appropriations Committee

AN ACT CONCERNING CHILDREN'S MENTAL HEALTH

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Prohibits prior authorization for acute inpatient psychiatric services provided (1) after an emergency department admission, (2) at an urgent crisis center, or (3) by referral because the insured poses an imminent danger to themselves or others; requires disclosures that the insured may incur out-of-network costs

§ 57 — OFFICE OF HEALTH STRATEGY REIMBURSEMENT RATE STUDY

Requires OHS to study the rates at which health carriers and TPAs in the state reimburse health care providers for physical, mental, and behavioral health benefits and report to the Insurance and Real Estate and Public Health committees by January 1, 2023, and January 1, 2024

§ 58 — OHS PAYMENT PARITY STUDY

Requires OHS to study certain payment parity-related issues for behavioral and mental health and other medical services under HUSKY Health and the private insurance market

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§ 69 — DPH GRANT TO CHILDREN'S HOSPITAL

Allows DPH, within available resources, to award a $150,000 grant in FY 23 to an in-state children's hospital for coordinating a mental and behavioral health training and consultation program; requires the hospital to report on the program

§ 70 — BEHAVIORAL AND MENTAL HEALTH POLICY AND OVERSIGHT COMMITTEE

Establishes a Behavioral and Mental Health Policy and Oversight Committee; requires the committee to evaluate and report on various matters related to the mental health system for children and develop a related strategic plan

§§ 71-73 — ADVERSE DETERMINATION NOTICES

Requires certain information on adverse determination notices to be prominently displayed and approved by the healthcare advocate

§ 1 — DPH PLAN FOR WAIVER OF LICENSURE REQUIREMENTS FOR CERTAIN PROVIDERS

Requires DPH, in consultation with DCF, to develop and implement a plan to waive licensure requirements for mental or behavioral health care providers licensed in other states (with priority given to children's providers)

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

to provide these services to children.

For this waiver to apply, the (1) other state must have requirements for practicing that are substantially similar to, or higher than, those in Connecticut and (2) provider must have no disciplinary history or pending unresolved complaints.

When developing and implementing the plan, the DPH commissioner must consider (1) eliminating barriers to the expedient licensure of these providers to immediately address the mental health needs of children in the state and (2) whether a waiver should be limited to telehealth.

Additionally, the act provides that any interstate licensure compact the state adopts for mental or behavioral health care providers would supersede the act's plan (see *Background*).

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

EFFECTIVE DATE: Upon passage

Background — Related Act

PA 22-81, §§ 42 & 43, enters Connecticut into the following two interstate compacts: the Psychology Interjurisdictional Compact and the Interstate Medical Licensure Compact.

§ 2 — EXPEDITED LICENSURE FOR HEALTH CARE PROVIDERS

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

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

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

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

EFFECTIVE DATE: October 1, 2022

§ 3 — SOCIAL WORK LICENSURE EXAMINATION ACCOMMODATIONS

Requires the DPH commissioner to notify clinical and master social worker license applicants that they may be eligible for certain testing accommodations

The act requires the DPH commissioner to notify every clinical and master social worker licensure applicant that he or she may be eligible for testing accommodations under the federal Americans with Disabilities Act or other accommodations determined by the Association of Social Work Boards, or its successor organization. Under the act, these accommodations may include (1) using a dictionary while taking the licensure exam or (2) additional time to complete the exam.

EFFECTIVE DATE: July 1, 2022

§ 4 — MASTER SOCIAL WORK LICENSE TEMPORARY PERMITS

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

Until June 30, 2024, the act extends the duration of temporary permits for master social workers from 120 days after attaining a master's degree to one year after permit issuance. It also specifies that a temporary permit is not void only because the applicant fails the examination. Starting July 1, 2024, the act reduces the duration of the temporary permits to 120 days after they are issued and makes them void if the applicant fails the licensure examination.

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

EFFECTIVE DATE: Upon passage

§ 5 — TELEHEALTH SERVICES BY OUT-OF-STATE SOCIAL WORKERS

Allows out-of-state social workers, under certain conditions, to provide telehealth services to residents of other states while the residents are in Connecticut, until July 1, 2024

Until July 1, 2024, the act allows an out-of-state social worker to provide telehealth services to a resident of another state while that resident is in Connecticut if the social worker:

1. is appropriately licensed in another U.S. state or territory, or the District of Columbia;
2. has a preexisting professional relationship with the resident; and
3. has professional liability insurance or other indemnity against professional malpractice liability in an amount at least equal to that required for Connecticut-licensed social workers.

The act allows out-of-state social workers to do this regardless of Connecticut's existing telehealth law and PA 21-9. Existing law generally sets requirements for authorized providers providing telehealth services. PA 21-9 temporarily replaces these requirements with similar, but more expansive requirements through June 30, 2023.

EFFECTIVE DATE: Upon passage

Background — Related Act

PA 22-81 extends PA 21-9's temporary expanded telehealth requirements by one year, through June 30, 2024.

§ 6 — NEED-BASED ASSISTANCE FOR MENTAL AND BEHAVIORAL HEALTH CARE LICENSURE APPLICANTS

Requires DPH, within available appropriations, to establish a need-based program that waives application and licensure fees for certain applicants who will provide children's mental or behavioral health services

The act requires the DPH commissioner to establish, within available appropriations, a need-based program that allows her to waive application and licensure fees for the following licensure applicants who will provide mental or behavioral health services to children: art therapists, behavior analysts, marital and family therapists, physicians, professional counselors, psychologists, and social workers. It allows DPH to accept private donations for the program.

Under the act, the commissioner must develop program eligibility requirements based on applicants' financial need and prioritize those who (1) are members of a racial or ethnic minority; (2) speak English as a second language; (3) identify as lesbian, gay, bisexual, transgender, or queer; or (4) have a disability.

EFFECTIVE DATE: Upon passage

§ 7 — CHILDREN'S MENTAL HEALTH ADVISORY BOARD

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

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

It adds the following 11 new members:

1. the correction and labor commissioners, or their designees;
2. the Office of Policy and Management (OPM) secretary, or his designee;
3. one representative of the governor's office, appointed by the governor;
4. one representative of commercial health insurance carriers, appointed by the governor;
5. one representative of the Commission on Racial Equity in Public Health, appointed by the commission;
6. one representative of the Commission on the Disparate Impact of COVID-19, appointed by the commission;
7. one representative of the task force studying mental health service provider

networks (as required under PA 21-125);
8. one representative of the task force studying children's needs (as required under PA 21-46); and
9. two additional appointees by the DCF commissioner.

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

Except for the correction and labor commissioners and the OPM secretary, all new appointments must be made by October 1, 2022. Under prior law, all board members served an initial three-year term and could not be reappointed. Under the act, the two task force appointees must serve only one two-year term and may not be reappointed.

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

EFFECTIVE DATE: July 1, 2022

§ 8 — MOBILE PSYCHIATRIC SERVICES DATA REPOSITORY

Requires DCF to establish and administer a mobile psychiatric services data repository for personnel to share best practices and experiences and collect data on patient outcomes

The act requires DCF, by January 1, 2023, to establish and administer a data repository for (1) emergency mobile psychiatric services personnel to share best practices and experiences while providing emergency mobile psychiatric services to children in the field and (2) the department and these personnel, when available and appropriate, to collect outcome data on children who received these services. For internal quality improvement purposes, this patient data must be deidentified and disaggregated.

EFFECTIVE DATE: July 1, 2022

Background — Related Act

PA 22-81, § 1, requires DCF to make mobile crisis response services available to the public 24 hours a day, seven days a week.

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

Establishes a pilot program in Waterbury that allows an FQHC to administer intensive outpatient services for adolescents with mental or behavioral health issues

The act establishes a pilot program in Waterbury, administered by DCF in consultation with the Department of Social Services (DSS), allowing a federally

qualified health center (FQHC) to administer intensive outpatient services, including an extended day treatment program, for adolescents with mental or behavioral health issues. The act requires the FQHC to administer these services to at least 144 adolescents annually for no less than five years. If the FQHC stops administering the services before October 1, 2027, it must reimburse the state for funds allocated to the pilot program in an amount prorated to the period the services were provided.

By January 1, 2024, and then annually until January 1, 2029, the act requires the DCF commissioner, in consultation with the DSS commissioner, to report to the Public Health and Children's committees on the pilot program's implementation. This report must assess the program's effectiveness and include legislative recommendations for implementing it statewide.

EFFECTIVE DATE: October 1, 2022

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

Expands DCF's regional behavioral health consultation and care coordinating program by, among other things, including mental health consultations and coordination and generally requiring it to refer the program's pediatric patients for up to three follow-up telehealth or in-person appointments

Existing law requires DCF's regional behavioral health consultation and care coordination program to provide certain services to primary care providers who serve children. The act expands the program to include mental health consultation and coordination and to provide program services to the provider's pediatric patients. Specifically, the act incorporates the program expansion to require that it give providers (1) timely access to a consultation team, including a child psychiatrist, social worker, and care coordinator; (2) patient care coordination and transitional services for mental or behavioral health care; and (3) training and education on patient access to mental and behavioral health services.

The act also requires the program to refer a provider's pediatric patients for up to three follow-up telehealth or in-person appointments with a mental or behavioral health care provider (1) if the provider determines it to be medically necessary and (2) after the primary care provider has used the program on the patient's behalf and the patient has been prescribed medication to treat a mental or behavioral health condition. The program must cover the appointment costs, within available appropriations.

The act requires the providers to refer the patients to a care coordinator who contracts with DCF, but is not participating in the program, to provide short-term assistance to the patients in getting mental or behavioral health care from a non-participating mental or behavioral health care provider.

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

The act also deletes obsolete language.

EFFECTIVE DATE: Upon passage

§ 11 — OFFICE OF HEALTHCARE ADVOCATE EMPLOYEE

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

The act requires the state's healthcare advocate, by October 1, 2022, to designate an Office of Healthcare Advocate employee to be responsible for (1) performing the office's duties for minors and (2) coordinating statewide efforts to ensure minors have coverage for, and access to, services for behavioral and mental health conditions and substance use disorders.
EFFECTIVE DATE: July 1, 2022

§ 12 — SCHOOL MENTAL HEALTH SPECIALIST EMPLOYMENT SURVEY

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

Beginning by July 1, 2023, the act requires the State Department of Education (SDE) commissioner to develop and distribute, within available appropriations, an annual survey to each local and regional board of education about its employment of school mental health specialists. Under the act, these specialists are school social workers, school psychologists, trauma specialists, behavior technicians, board-certified behavior analysts, school counselors, licensed professional counselors, licensed marriage and family therapists, or any other people employed to provide mental health services to students.

The act requires the survey to include at least the following:

1. the total number of school mental health specialists for the district as a whole and for each individual school in the district;
2. a disaggregation of the total number of school social workers, school psychologists, trauma specialists, behavior technicians, board-certified behavior analysts, school counselors, licensed professional counselors, and licensed marriage and family therapists (a) in the district and (b) in each school in the district, including whether any are assigned to just one school or to multiple schools;
3. the geographic area covered by any school mental health specialist who provides services to more than one board of education;
4. an estimate of the annual number of students who received direct services from each individual school mental health specialist during the five years before the survey's completion; and
5. data, if any, about school-based behavioral health services provided for a school board contractually by a private provider, including the (a) types of services; (b) schools, grade levels, and number of students receiving these services; and (c) total board expenditures for these services under the contract during the previous school year.

Beginning in the 2023-24 school year, each board of education must annually complete the survey and submit it to the commissioner when and how she determines. After receiving a completed survey, the commissioner must annually

calculate the student-to-school mental health specialist ratios for the board and for each school under its jurisdiction. The commissioner must annually report the survey results and ratios to the Children's and Education committees starting by January 1, 2024.
EFFECTIVE DATE: Upon passage

§ 13 — GRANT FOR HIRING SCHOOL MENTAL HEALTH SPECIALISTS

Requires SDE to administer a grant program for FYs 23-25 to provide funding to school boards to hire additional school mental health specialists

The act requires SDE to administer a program to provide grants in FYs 23-25 to local and regional boards of education for hiring additional school mental health specialists. It allows SDE to accept the following funding sources to support the program: (1) private source or state agency funds and (2) gifts, grants, and donations, including in-kind donations. (PA 22-116, § 10, (1) requires any school counselor hired through this grant program to provide one-on-one student consultations about completion of the Free Application for Federal Student Aid (FAFSA) and (2) provides for a larger grant amount for such boards who can prove that the district's FAFSA completion rate increased by at least 5%.)
EFFECTIVE DATE: July 1, 2022

Application Process

Under the act, boards may file grant applications with the education commissioner beginning on January 1, 2023, in a form and way she determines. Boards that apply before July 1, 2023, must submit the minimum information required by the act for the school mental health specialist employment survey; those that apply on or after July 1, 2023, must submit a copy of their completed survey (see § 12 above).

Regardless of their application date, all boards must also submit a plan for grant fund spending. The plan must include at least the following information: (1) the number of additional specialists to be hired, (2) whether previously hired specialists will be retained with these grant funds, (3) whether these specialists will be conducting student assessments or providing student services based on the assessment's results, and (4) the type of services that the specialists will provide. (PA 22-116, § 10, requires the applicant districts' grant spending plans to describe how the board will implement the FAFSA counseling requirements and demonstrate FAFSA completion rates.)

Award Process

The act authorizes the commissioner to determine (1) whether to award grants to applicant boards in FY 23 and (2) the amount of a recipient's initial grant award based on its submitted plan. However, it requires the commissioner to prioritize school districts with a large student-to-specialist ratio or a high volume of students using mental health services.

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

Program Tracking

Under the act, grant recipients must file annual expenditure reports with SDE. The act limits grant recipients' expenditures to those consistent with the grant spending plan submitted as part of their application. It also prohibits them from using grant funds on operating expenses that existed before they received these funds. Additionally, the act requires grant recipients to refund to SDE (1) any unspent grant amount at the end of the fiscal year when it was awarded and (2) any grant amount that was spent inconsistently with the plan submitted in the grant application.

The act requires SDE to annually track and calculate each recipient's grant program utilization rate and the grant program's return on investment. The department must calculate the utilization rate using metrics that at least include the number of students served and service hours provided using grant program funds. SDE must calculate the program's return on investment using the utilization rate calculations and expenditure reports filed by the grant recipients.

Reports to the Legislature

By each January 1 in 2024 through 2026, the act requires the education commissioner to report to the Children's and Education committees on each grant recipient's utilization rate and the grant program's return on investment.

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

§ 14 — GRANT FOR DELIVERY OF STUDENT MENTAL HEALTH SERVICES

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

The act requires SDE to administer a program to provide grants in FYs 23-25 to boards of education, youth camp operators, and other summer program operators for delivery of student mental health services. It allows SDE to accept the following funding sources to support the program: (1) private source or state agency funds and (2) gifts, grants, and donations, including in-kind contributions.

EFFECTIVE DATE: Upon passage

Application Process

Beginning January 1, 2023, applicants must file grant applications with the education commissioner when and how she determines. Boards of education that apply before July 1, 2023, must submit the minimum information required by the act for the student mental health specialist employment survey; those that apply on or after July 1, 2023, must submit a copy of their completed survey (see § 12 above). Additionally, all applicants must submit a plan for grant fund spending regardless of their application date.

Award Process

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

Program Tracking

Under the act, grant recipients must file expenditure reports with SDE as the commissioner directs. The act limits grant recipients' expenditures to those consistent with the grant spending plan submitted as part of their application. It also prohibits them from using grant funds on operating expenses that existed before they received these funds. Additionally, the act requires grant recipients to refund to the department (1) any unspent grant amount at the end of the fiscal year when it was awarded and (2) any grant amount spent inconsistently with the plan submitted in the grant application.

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

Reports to the Legislature

By each January 1 in 2024 through 2026, the act requires the education commissioner to report to the Children's and Education committees on each grant recipient's utilization rate.

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

§ 15 — GRANT FOR COLLEGE AND UNIVERSITY DELIVERY OF STUDENT MENTAL HEALTH SERVICES

Requires OHE to administer a grant program for FYs 23-25 to provide funding to public and private colleges and universities for delivery of student mental health services

The act requires the Office of Higher Education (OHE) to administer a program to provide grants in FYs 23-25 to public and private higher education institutions to deliver student mental health services on campus. It allows OHE to accept the following funding sources to support the program: (1) private source or state agency funds and (2) gifts, grants, and donations, including in-kind contributions.
EFFECTIVE DATE: Upon passage

Application Process

Beginning January 1, 2023, applicants must file grant applications with the OHE executive director when and how he determines. As part of its application, an institution must submit a plan for grant fund spending.

Award Process

The act authorizes OHE's executive director to determine (1) whether to award grants to applicants in FY 23 and (2) the amount of a recipient's initial grant award based on its submitted plan. It establishes the following grant amounts for the executive director to award for the duration of the grant program: for FY 23, a commissioner-determined amount; for FY 24, the same amount awarded in FY 23; and for FY 25, 70% of the amount awarded in FY 24. (Presumably, the OHE executive director, not a commissioner, is calculating the FY 23 amount.)

Program Tracking

Under the act, grant recipients must file expenditure reports with the OHE executive director as he directs. The act limits grant recipients' expenditures to those consistent with the grant spending plan submitted as part of their application. It also prohibits them from using grant funds on operating expenses that existed before they received these funds. Additionally, the act requires grant recipients to refund to the office (1) any unspent grant amount at the end of the fiscal year when it was awarded and (2) any grant amount spent inconsistently with the plan submitted in the grant application.

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

Reports to the Legislature

By each January 1 in 2024 through 2026, the act requires the OHE executive director to report to the Higher Education and Employment Advancement Committee on each grant recipient's utilization rate.

The act also requires the executive director to develop recommendations on the following topics and submit them to the same committee by January 1, 2026: (1) whether this grant program should be extended and funded for FY 26 and beyond

and (2) the grant award amount under the program.

§§ 16 & 21 — STUDENT TRUANCY AND BEHAVIORAL HEALTH INTERVENTIONS

Requires each school district to adopt and implement three new policies or procedures related to truant students; requires SDE to develop a truancy intervention model that accounts for mental and behavioral health; requires SDE, along with DCF, to issue guidance to school districts on best practices for behavioral health interventions and when to call the 2-1-1 Infoline program or use alternative interventions

School District Truancy Policies and Procedures (§ 16)

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

The act adds three new requirements. First, it requires school districts to notify a truant child's parent or guardian about the availability of the 2-1-1 Infoline program and other pediatric mental and behavioral health screening services and tools.

The act also requires that, beginning July 1, 2023, an appropriate student mental health specialist (as defined in § 12) evaluate each child who is a truant to determine if more behavioral health interventions are necessary for the child's well-being.

Lastly, the act requires each school district, by September 1, 2023, to adopt and implement (1) an SDE-developed truancy intervention model that accounts for mental and behavioral health or (2) a truancy intervention plan that meets the SDE truancy model requirements.

SDE Truancy Intervention Model (§ 21)

The act requires SDE to develop a truancy intervention model that accounts for mental and behavioral health and make it available for school districts' implementation by September 1, 2023. Existing law requires the department to have an intervention model available for school districts it identifies as having a disproportionally high level of truancy (CGS § 10-198a(b)(5)).

Behavioral Health Interventions (§ 21)

The act requires SDE to collaborate with DCF to issue guidance to boards of education by September 1, 2023, on (1) best practices for behavioral health interventions and (2) when to call the 2-1-1 Infoline program or use alternative interventions.

EFFECTIVE DATE: July 1, 2022

§§ 17 & 18 — REGIONAL STUDENT TRAUMA COORDINATORS

Requires each of the state's six regional educational service centers to hire a regional trauma coordinator to, among other things, develop and implement a trauma-informed care training

program; requires coordinators to train specialists at the local level to train teachers, administrators, and other staff; requires a progress report and a final report to be submitted to the Children's and Education committees

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

Specifically, the act requires the RESC coordinators to jointly develop and implement the training program with a training model enabling student mental health specialists to deliver trauma-informed care training for all teachers, administrators, and other school staff and coaches when they complete the program. In developing the training program, the regional trauma coordinators may collaborate with nonprofit organizations in the state that focus on child health and development and trauma-informed care for children.

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

The act requires the regional trauma coordinators to attempt to design the training so that it can be included as part of a school district's required in-service training. It permits a board of education to enter into an agreement with the RESC trauma coordinator to provide the trauma-informed care training program as part of the school district's in-service training program.

EFFECTIVE DATE: July 1, 2022

Progress Report and Final Report

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

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

§ 19 — BEHAVIOR INTERVENTION MEETINGS

Allows classroom teachers to request behavior intervention meetings for students exhibiting seriously disruptive or physically harmful behavior; requires the school's crisis intervention team to convene them

Beginning in the 2022-23 school year, the act allows any classroom teacher to request a behavior intervention meeting with the school's crisis intervention team for any student whose behavior has caused (1) a serious disruption to other students' instruction or (2) self-harm or physical harm to the teacher, another student, or staff in the teacher's classroom. By law, a school's crisis intervention team responds to incidents where physical restraint or seclusion may be necessary to prevent immediate or imminent injury to a student or others. The school principal designates the team members, consisting of a teacher, administrator, and school paraprofessional or other school employee who has direct contact with students (CGS § 10-236b(o)(2)).

Under the act, the crisis intervention team must call the meeting, and its participants must identify resources and supports to address the student's social, emotional, and instructional needs.

EFFECTIVE DATE: July 1, 2022

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

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

Existing law requires each school district superintendent to annually submit to SDE a strategic school profile that, among other things, provides information on measures of student needs. The act requires superintendents to include, as part of this category, a needs assessment that identifies resources needed to (1) address student trauma impacting students and staff in each school and (2) adequately respond to students with mental, emotional, or behavioral health needs.

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

EFFECTIVE DATE: July 1, 2022

§ 22 — STATEWIDE EMERGENCY SERVICE TELECOMMUNICATIONS PLAN

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

By law, the Department of Emergency Services and Public Protection's (DESPP's) Division of State-Wide Emergency Telecommunications, in cooperation with the Public Utilities Regulatory Authority, must develop a statewide emergency service telecommunications plan identifying emergency police, fire, and medical service telecommunications systems needed to provide

coordinated emergency service telecommunications to all state residents, including those with physical disabilities. The act specifies that the plan must also address residents who need mental health, behavioral health, or substance use disorder services.
EFFECTIVE DATE: October 1, 2022

§ 23 — E 9-1-1 COMMISSION

Expands the E 9-1-1 Commission by adding the DPH, DMHAS, and DCF commissioners, or their designees, as members

The act increases the E 9-1-1 Commission's membership by adding the DPH, Department of Mental Health and Addiction Services (DMHAS), and DCF commissioners, or their respective designees. By law, the commission generally advises DESPP on planning, designing, implementing, and coordinating the statewide emergency 9-1-1 telephone system and the public safety data network. Its membership consists largely of representatives from fire, police, telecommunication, and emergency services.
EFFECTIVE DATE: October 1, 2022

§ 24 — DESPP COORDINATING ADVISORY BOARD

Expands the DESPP Coordinating Advisory Board by adding the DMHAS and DCF commissioners as members

The act expands the DESPP Coordinating Advisory Board's membership by adding the DMHAS and DCF commissioners. By law, the board advises DESPP on ways to improve emergency response communications and related matters. Its membership consists largely of representatives from fire, police, public health, and emergency services. The DESPP commissioner, or the commissioner's designee, serves as the chairperson.
EFFECTIVE DATE: October 1, 2022

§ 25 — 9-8-8 SUICIDE PREVENTION AND MENTAL HEALTH CRISIS LIFELINE FUND

Establishes a "9-8-8 Suicide Prevention and Mental Health Crisis Lifeline Fund" as a separate, non-lapsing General Fund account

A 2020 federal law (P.L. 116-172) designated 9-8-8 as the national suicide prevention and mental health crisis hotline, operational as of July 16, 2022.

The act establishes the "9-8-8 Suicide Prevention and Mental Health Crisis Lifeline Fund" as a separate, non-lapsing General Fund account. DMHAS must use the account's funds only for (1) ensuring the efficient and effective routing of in-state calls made to 9-8-8 to an appropriate crisis center and (2) funding personnel and the provision of acute mental health, crisis outreach, and stabilization services by directly responding to 9-8-8.

The act requires that the following be deposited or transferred into the fund: (1) any General Fund appropriation to DMHAS directed to the fund; (2) any grants or gifts intended for the fund; and (3) fund interest, premiums, gains, or other earnings. It also prohibits any money in the fund from being transferred or otherwise diverted for other purposes.

The act requires the DMHAS commissioner to annually report on the fund's deposits and expenditures beginning by January 1, 2024, to the Appropriations, Children's, Human Services, and Public Health committees.

EFFECTIVE DATE: October 1, 2022

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

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

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

1. staffing PSAPs with licensed mental and behavioral health and substance abuse disorder service providers to (a) provide crisis counseling to 9-1-1 callers who immediately require these services, (b) assess their need for ongoing services, and (c) if needed, refer them to service providers;
2. transferring callers who require these services to responders, other than law enforcement (e.g., community organizations, mobile crisis teams, local organizations, or networks), who provide telephone support or referral services for people with mental or behavioral health needs or a substance use disorder, and asking whether these callers are veterans to better target the necessary services;
3. requiring PSAPs to coordinate with DMHAS during the state's transition of mental health crisis and suicide response from the United Way's 2-1-1 Infoline program to the National Suicide Prevention Lifeline's 9-8-8 program;
4. developing protocols for transferring 9-1-1 calls to the 9-8-8 line when it is operational;
5. setting standards for training telecommunicators (i.e., 9-1-1 emergency dispatchers) to respond to 9-1-1 callers who may require mental or behavioral health or substance use disorder services;
6. collecting data to evaluate the effectiveness of procedures used to divert 9-1-1 callers who may need these services to the appropriate crisis hotline or services provider; and
7. evaluating how other states or jurisdictions implemented these procedures.

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

EFFECTIVE DATE: Upon passage

§ 27 — TRACKING OF SERVICES IN RESPONSE TO 9-8-8 CALLS

Requires DMHAS to develop and report on a mechanism to track services provided in response to 9-8-8 calls

The act requires DMHAS, by January 1, 2024, to develop a mechanism to track mental health, behavioral health, and substance use disorder services provided in response to 9-8-8 calls (see § 25). By February 1, 2024, the DMHAS commissioner must report on its development to the Public Health Committee.
EFFECTIVE DATE: Upon passage

§ 28 — MIDDLE AND HIGH SCHOOL STUDENT IDENTIFICATION CARDS

Requires public schools to include the National Suicide Prevention Lifeline number on student identification cards for grades 6-12

The act requires each local and regional board of education, beginning in the 2023-24 school year, to include the 9-8-8 National Suicide Prevention Lifeline number on the student identification cards distributed to students in grades 6-12. If the 9-8-8 number has not been operational for more than one year before the 2023-24 school year begins, then the act postpones this requirement until a future school year immediately after the number has been operational in Connecticut for 366 days.
EFFECTIVE DATE: July 1, 2022

§§ 29 & 30 — COLLEGE AND UNIVERSITY IDENTIFICATION CARDS

Requires all public colleges and universities to include the National Suicide Prevention Lifeline number on student ID cards

The act requires UConn, each of the Connecticut State Universities and regional-technical community colleges, and Charter Oak State College to include the 9-8-8 National Suicide Prevention Lifeline number on each student identification card. This requirement takes effect once the lifeline has been operational in Connecticut for 366 days.
EFFECTIVE DATE: October 1, 2022

§ 31 — CERTIFICATE OF NEED FOR MENTAL HEALTH FACILITIES

Temporarily exempts from CON requirements increases in mental health facilities' licensed bed capacity under certain conditions; requires OHS to report on any recommendations for establishing an expedited CON process for mental health facilities

Generally, existing law requires health care facilities to apply for and receive a certificate of need (CON) from the Office of Health Strategy's (OHS) Health Systems Planning Unit when proposing to establish a new facility or provide new

services, change ownership, purchase or acquire certain equipment, or terminate certain services.

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

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

EFFECTIVE DATE: Upon passage

Temporary CON Exemption for Bed Capacity Increases

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

1. individual or group health insurance policies that cover (a) basic hospital expenses; (b) basic medical-surgical expenses; (c) major medical expenses; or (d) hospital or medical services, including those provided under an HMO plan;
2. self-insured plans under the federal Employee Retirement Income Security Act (ERISA); and
3. HUSKY Health (i.e., Medicaid and the state children's health insurance program).

The exemption ends if the mental health facility does not accept or stops accepting reimbursement for any covered benefit under these policies, plans, or programs.

By June 30, 2026, a facility seeking to increase its licensed bed capacity without applying for a CON must notify OHS of its intent to do so, as well as its address and a description of all its current or planned services. The OHS executive director sets the form and manner of this notice.

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

Establishes a Mental and Behavioral Health Treatment Fund, administered by DCF to assist families with the costs of obtaining prescribed drugs or treatments and intensive services for children with mental and behavioral health conditions if insurance or Medicaid does not cover them

Funding and Program Purpose

The act establishes a Mental and Behavioral Health Treatment Fund as a separate, nonlapsing General Fund account. The account must contain any funds the law requires to be deposited in it and the DCF commissioner must use the funds to help families pay for prescription drugs or certain treatment and intensive services for children to treat a mental or behavioral health condition if insurance or Medicaid does not cover the cost.

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

The act authorizes the DCF commissioner to (1) accept, on the fund's behalf, any federal funds or private grants or gifts made for the grant program and (2) use the funds to make grants to families for the act's purposes.

Program Eligibility

The act requires the DCF commissioner to establish eligibility criteria for families to receive the assistance and start accepting grant applications by January 1, 2023.

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

Program Description on the Departments' Websites and in Certain Resources

Websites. By January 1, 2023, the act requires DCF, the Department of Consumer Protection, and OPM to post in a conspicuous location on their respective websites the grant program's description, including the eligibility requirements and application process. The OPM secretary may request that another state agency also post this information on its website.

Resources. Under the act, the description DCF posts on its website, as required above, must also include information on resources for connecting children and families to behavioral health services. The act also requires DCF to:

1. include the description in the children's behavioral and mental health resources document the department creates for each mental health region and
2. provide the description to the 2-1-1 Infoline program operated by the United Way of Connecticut.

Reporting

The act requires the DCF commissioner to annually report on the program's effectiveness to the Public Health Committee, starting by January 1, 2024.

EFFECTIVE DATE: Upon passage

§ 33 — PEDIATRIC MENTAL HEALTH SCREENING TOOL

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

The act requires DPH, by January 1, 2023, to develop or procure a pediatric mental health, behavioral health, and substance use disorder screening tool. DPH

must do so in consultation with DCF, a Connecticut children's hospital representative, and the Connecticut chapter of a national professional association of (1) pediatricians and (2) child and adolescent psychiatrists.

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

By January 1, 2023, the act requires DPH, in collaboration with DCF and DMHAS, to make the screening tool available to all pediatricians and emergency department physicians in the state, free of charge, and make recommendations to pediatricians and emergency department physicians for its effective use. It requires pediatricians and emergency department physicians to use the screening tool as a supplement to the existing methods used to diagnose a mental or behavioral health condition or a substance use disorder.

Under the act, pediatricians must provide the screening tool to each patient annually, and emergency department physicians must (1) provide the screening tool to each emergency department patient under age 18 and at least the minimum department-determined age, or the parents or guardian, before the child's discharge from the emergency department and (2) send a copy of it to the child's pediatrician or primary care provider to the extent possible and as soon as practicable.
EFFECTIVE DATE: Upon passage

§§ 34-36 — PEER-TO-PEER MENTAL HEALTH SUPPORT PROGRAM

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

The act requires DCF, working with SDE, to create a peer-to-peer mental health support program available to (1) local and regional boards of education, (2) local and district health departments, (3) youth service bureaus, (4) municipal social service agencies, and (5) other DCF-approved youth-serving organizations. The program must provide services to help students in grades 6 through 12 with problem solving, decision making, conflict resolution, and stress management.

The act requires the departments to develop the program by January 1, 2023. They also must provide training, beginning January 1, 2023, on the program's implementation and student instruction, guidance, and supervision to designated school staff members (see below) and employees of the entities described above.

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

Under the act, beginning with the 2023-2024 school year, local and regional boards of education may begin administering the program to participating students in grades 6-12. The other entities described above may begin administering the

program to these students on or after July 1, 2023.

The superintendent for each school district administering the program must select at least one "designated staff member" to complete the DCF-SDE training (i.e., a teacher, school administrator, school counselor, psychologist, social worker, nurse, physician, or school paraeducator (1) employed by a local or regional board of education or (2) working in a public middle or high school). The other entities administering the program must select at least one employee to do so as well.

EFFECTIVE DATE: July 1, 2022

§ 37 — DCF IN-HOME RESPITE CARE SERVICES PROGRAM

Requires the DCF commissioner to set up an in-home respite care services program to help parents and guardians of children with behavioral health needs and creates a General Fund account dedicated to the program

The act requires the DCF commissioner, by January 1, 2023, to set up a program to provide in-home care services for children with behavioral health needs (i.e., children who are suffering from one or more mental disorders as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders") to give their parents and guardians a break from caregiving. DCF must administer the program by contracting with in-home respite care service providers or giving these children's parents and guardians direct subsidies to purchase these services.

Relatedly, the act creates a "Department of Children and Families In-home Respite Care Services Fund" as a separate, nonlapsing account within the General Fund. The account must contain any moneys that the law requires to be deposited in it. Account funds must be spent by the DCF commissioner for funding the above in-home respite care services program.

The act also allows the DCF commissioner to adopt regulations to carry out these provisions, including eligibility criteria for participating in the program. The act requires DCF to implement policies and procedures to administer the program while adopting regulations, as long as the department posts notice of intent to adopt the regulations on the state's eRegulations System within 20 days of implementing the policies and procedures. The policies and procedures are valid until regulations are adopted.

EFFECTIVE DATE: July 1, 2022

§ 38 — CHILD AND ADOLESCENT PSYCHIATRIST GRANT PROGRAM

Requires DPH to establish a child and adolescent psychiatrist grant program for incentive grants to employers to recruit, hire, and retain these psychiatrists

The act requires DPH, by January 1, 2023, to establish and administer a grant program to incentivize employers of child and adolescent psychiatrists to recruit and hire new psychiatrists and retain those whom they employ. It requires the DPH commissioner to establish (1) eligibility requirements; (2) priority categories, including nonhospital employers; (3) funding limitations; and (4) the application

process. The commissioner, in consultation with OHS, must distribute grant funds equitably with regard to employer type and location.

Starting by January 1, 2024, the commissioner must annually report to the Public Health Committee on (1) the number and demographics of the employers who applied for and received incentive program grants, (2) the recipients' use of grant funds, and (3) any other information the commissioner considers pertinent.
EFFECTIVE DATE: Upon passage

§ 39 — DMHAS ADVERTISING CAMPAIGN

Requires DMHAS, in collaboration with DCF, to (1) plan and implement a statewide advertising campaign on available mental and behavioral health and substance use disorder services and (2) set up a related website

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

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

The act requires the DMHAS commissioner to solicit cooperation and participation from these providers in the advertising campaign, including soliciting any available funds. It allows the commissioner to hire consultants with advertising expertise to help implement these provisions.
EFFECTIVE DATE: Upon passage

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

Requires the DCF-contracted peer-to-peer support program for parents and caregivers of children with behavioral health needs to use allocated state funds to provide services to those who are not covered for these services under HUSKY Health or a health insurance policy

The act requires the peer-to-peer support program that provides services to parents and caregivers of children with mental and behavioral health issues to use state funds allocated for the program to provide services to those who are not covered for these services under (1) HUSKY Health or (2) an individual or group health insurance policy. The act allows the program, which is operated by an administrative services organization that contracts with DCF, to continue to provide services to parents and caregivers of children covered under HUSKY Health if the program exhausts allocated state funds.

Under the act, the DCF commissioner may adopt policies and procedures for program administration.
EFFECTIVE DATE: Upon passage

§§ 41 & 42 — MENTAL HEALTH WELLNESS EXAMS

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

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

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

1. observation;
2. a behavioral health screening;
3. education and consultation on healthy lifestyle changes;
4. referrals to ongoing treatment, mental health services, and other necessary supports;
5. discussion of potential medication options;
6. age-appropriate screenings or observations to understand the insured's mental health history, personal history, and mental or cognitive state; and
7. relevant input from an adult through screenings, interviews, or questions if appropriate.

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

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

EFFECTIVE DATE: January 1, 2023

Coverage Applicability

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

Cost Sharing Applicability

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

§§ 43 & 44 — HEALTH INSURANCE COVERAGE FOR INTENSIVE SERVICES FOR MENTAL CONDITIONS

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

The act requires certain health insurance policies to cover intensive services for treating a child's mental or nervous condition that are evidence-based, in addition to ones that are home-based, as existing law requires. The act also expands this coverage to include services designed for adolescents, rather than those only for children, as under prior law.

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

EFFECTIVE DATE: January 1, 2023

§ 45 — PSYCHOLOGY DOCTORAL STUDENT CLERKSHIP PROGRAM

Requires DPH to establish an incentive program to allow two-year, rather than annual, license renewal for psychology doctoral students' first four years of licensure if they complete a clerkship at certain DCF-licensed or -operated facilities

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

Under the act, this clerkship requires the candidate to work 12 to 16 hours per week as a psychological assessor or psychotherapist under the supervision of an agency-affiliated psychologist and at least one core faculty member of the doctoral degree program. The candidate's program of study must (1) be primarily psychological and (2) occur at an educational institution approved by DPH under existing law for psychologist licensure.

The act allows anyone completing the clerkship to renew his or her psychologist license every two years, rather than annually, during the first four years of licensure.

EFFECTIVE DATE: July 1, 2022

§ 46 — PROTOCOLS FOR EMS TRANSPORT

Requires DPH's Office of Emergency Medical Services to develop protocols for EMS organizations or providers to transport pediatric patients with mental or behavioral health needs by ambulance to DCF-licensed urgent crisis centers

The act requires DPH's Office of Emergency Medical Services (OEMS), by January 1, 2024, to develop protocols for licensed or certified emergency medical services (EMS) organizations or providers to transport pediatric patients with mental or behavioral health needs by ambulance to DCF-licensed urgent crisis centers. These centers must be dedicated to treating children's urgent mental or behavioral health needs.

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

EFFECTIVE DATE: October 1, 2022

§§ 47 & 48 — HEALTH INSURANCE COVERAGE FOR COLLABORATIVE CARE MODEL SERVICES

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

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

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

1. HCPCS G2214, initial or subsequent psychiatric collaborative care management, in consultation with other collaborative care team professionals (i.e., tracking or following up on patient progress);
2. CPT 99484, clinical staff time for behavioral health care management conditions;
3. CPT 99492, initial psychiatric collaborative care management;
4. CPT 99493, subsequent psychiatric collaborative care management; and
5. CPT 99494, additional initial or subsequent psychiatric collaborative care management.

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

plan adopts enacted benefits.)
EFFECTIVE DATE: January 1, 2023

§§ 49-56 — EXPANDED HEALTH INSURANCE COVERAGE FOR CERTAIN EMERGENCY SERVICES AND DCF-LICENSED URGENT CRISIS CENTERS

Broadly expands health insurance coverage for and emergency access to DCF-licensed urgent crisis center services, including by (1) prohibiting balance billing, higher out-of-network billing, and prior authorization and (2) requiring 24-hour, 7-day per week access to services

Prior Authorization, Cost Sharing, and Maximum Billable Amounts (§ 49)

The act prohibits health carriers from (1) requiring prior authorization for urgent crisis center services or (2) imposing a cost-sharing level for out-of-network services provided at these urgent crisis centers that is greater than the in-network level. Under the act, an "urgent crisis center" is a DCF-licensed center dedicated to treating children's urgent mental or behavioral health needs, and "urgent crisis center services" are pediatric mental and behavioral health services provided at one of these centers.

The act also establishes the maximum allowable billable and reimbursable amounts for services provided at an out-of-network urgent crisis center. For these services, a provider may bill the carrier directly, and a carrier must reimburse the center or insured, for the in-network rate as payment in full. As with existing law for out-of-network emergency services, a provider and carrier may agree to a different rate.

Prohibits Balance Billing (§§ 50 & 51)

The act makes it a Connecticut Unfair Trade Practices Act (CUTPA) violation for a health care provider to "balance bill" an insured for covered services that are provided by an out-of-network provider at a DCF-licensed urgent crisis center (i.e., bill more than the collectable cost-sharing under the policy).

The act also prohibits any health care center (i.e., HMO) provider, agent, trustee, or assignee from requesting any payment from an enrollee for covered services provided by an out-of-network provider at one of these crisis centers. It additionally requires all HMO contracts with providers to disclose that doing so is a CUTPA violation.

Among other things, CUTPA allows the consumer protection commissioner to investigate complaints, issue cease and desist orders, and order restitution in certain cases. It also allows individuals to sue. Courts may issue restraining orders; award actual and punitive damages, costs, and reasonable attorney's fees; and impose civil penalties of up to $5,000 for willful violations and $25,000 for restraining order violations (CGS § 42-110a et seq.).

Applicability (§ 49)

The provisions described above (i.e., prior authorization, cost sharing, billable

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

However, for plans that are HDHPs, it applies only to the maximum extent (1) permitted by federal law and (2) that does not disqualify someone who establishes an HSA, MSA, or Archer MSA from receiving the associated federal tax benefits. Under federal law, individuals with eligible HDHPs may make pre-tax contributions to an HSA, MSA, or Archer MSA and use the account for qualified medical expenses.

Full Week, 24-Hour Access to Services (§ 52)

By law, health carriers must provide covered people with access to emergency services 24 hours per day, seven days per week. The act requires carriers to also ensure that covered people have the same access to DCF-licensed urgent crisis center services, to the extent they are available.

Expanded Treatment Coverage for Mental or Nervous Conditions (§§ 53 & 54)

By law and with the exception of emergency services or certain referrals, HMOs are not required to cover state-mandated treatments for mental or nervous conditions at unaffiliated facilities. By also excluding services rendered at a DCF-licensed urgent crisis center, the act requires HMOs to cover these services even when provided at unaffiliated facilities.

EFFECTIVE DATE: January 1, 2023

§§ 55 & 56 — PROHIBITING PRIOR AUTHORIZATION FOR CERTAIN EMERGENCY ACUTE INPATIENT PSYCHIATRIC SERVICES

Prohibits prior authorization for acute inpatient psychiatric services provided (1) after an emergency department admission, (2) at an urgent crisis center, or (3) by referral because the insured poses an imminent danger to themselves or others; requires disclosures that the insured may incur out-of-network costs

The act prohibits certain individual and group health insurance policies that cover acute inpatient psychiatric services from requiring prior authorization if these services are provided:

1. after a hospital emergency department admission;
2. by referral from the insured's treating physician, psychologist, or APRN if the insured poses an imminent danger to self or others; or
3. at a DCF-licensed urgent crisis center.

The act specifies that it does not preclude a health carrier from using other forms of utilization review, including concurrent and retrospective review.

The act requires health care providers delivering acute inpatient psychiatric services, when admitting the insured, as well as any physicians, psychologists, or

APRNs, when making a referral, to give the insured a written notice stating that they may:

1. incur out-of-pocket costs if the services are not covered by health insurance and
2. choose to wait for an in-network bed for the services, or risk incurring out-of-network costs.

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

However, for HDHPs, the provisions apply only to the maximum extent (1) permitted by federal law and (2) that does not disqualify someone who establishes an HSA, MSA, or Archer MSA from receiving the associated federal tax benefits. Under federal law, individuals with eligible HDHPs may make pre-tax contributions to an HSA, MSA, or Archer MSA and use the account for qualified medical expenses.

EFFECTIVE DATE: January 1, 2023

§ 57 — OFFICE OF HEALTH STRATEGY REIMBURSEMENT RATE STUDY

Requires OHS to study the rates at which health carriers and TPAs in the state reimburse health care providers for physical, mental, and behavioral health benefits and report to the Insurance and Real Estate and Public Health committees by January 1, 2023, and January 1, 2024

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

1. the viability of implementing a sliding scale of reimbursement rates in the state,
2. how much reimbursement rates for mental and behavioral health benefits would need to increase to (a) attract more providers of covered mental and behavioral health benefits and (b) encourage existing providers to accept new patients,
3. the potential total savings to health carriers if insureds had more access to providers of covered mental and behavioral health benefits,
4. reimbursement rates for mental and behavioral health benefits paid by private health insurance policies compared to what the state or other governmental payors pay,
5. reimbursement rates for children's mental and behavioral health benefits compared to adults', and
6. the number of children referred for these benefits compared to the number who receive them.

In conducting the study, OHS may coordinate with the Connecticut Insurance Department and use information from the state's all-payer claims database.

The act requires OHS to report its interim study results to the Insurance and

Real Estate and Public Health committees by January 1, 2023, and final study results by January 1, 2024.
EFFECTIVE DATE: Upon passage

§ 58 — OHS PAYMENT PARITY STUDY

Requires OHS to study certain payment parity-related issues for behavioral and mental health and other medical services under HUSKY Health and the private insurance market

The act requires OHS, in consultation with the insurance and DSS commissioners, to study whether payment parity exists between the following:

1. providers of behavioral and mental health services and providers of other medical services in the private insurance market;
2. these providers within the HUSKY Health program (i.e., Medicaid and the state children's health insurance program); and
3. behavioral and mental health providers within the HUSKY Health program and the private insurance market.

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

Under the act, the OHS executive director must submit a report with interim study results by January 1, 2023, and a final report by January 1, 2024, to the Appropriations, Human Services, Insurance, and Public Health committees.
EFFECTIVE DATE: Upon passage

§ 59 — MEDICAID REIMBURSEMENT SYSTEM TO ENCOURAGE COLLABORATION

Requires DSS to implement a Medicaid reimbursement system to encourage collaboration between primary care providers and behavioral and mental health providers

The act requires the DSS commissioner to implement a Medicaid reimbursement system, to the extent federal law allows, that encourages collaboration between primary care providers and behavioral and mental health care providers and recognizes that multiple providers may be involved in providing care. The act allows the commissioner to consider the potential impact on federal reimbursement when implementing the system.

The act allows the DSS commissioner to adopt the Collaborative Care Model to expand access to behavioral and mental health services for HUSKY Health program members. Under this model, a primary care team delivers integrated behavioral health and primary care services. The team includes a primary care provider, a psychiatric consultant, and a behavioral care manager who uses a database to track patient progress. The act also allows DSS to use the billing system developed by the federal Centers for Medicare and Medicaid Services that provides Medicaid rates for services provided under this model.

By law, HUSKY Health includes Medicaid (under HUSKY A, C, and D) and the Children's Health Insurance Program (under HUSKY B) (CGS § 17b-290).
EFFECTIVE DATE: July 1, 2022

§§ 60 & 61 — YOUTH SERVICE CORPS PROGRAM AND GRANTS

Establishes a YSC grant program administered by DECD to provide grants to municipalities with priority school districts for paid community-based service learning and academic and workforce development programs for eligible youth and young adults

The act establishes a youth service corps (YSC) grant program to provide grants to municipalities with priority school districts (PSDs) to establish programs that provide paid, community-based service learning and academic and workforce development programs to eligible Connecticut youth and young adults (i.e., local YSC programs). By law, priority school districts are those whose students receive low standardized test scores and have high levels of poverty (CGS § 10-266p(a)).

Under the act, the Department of Economic and Community Development (DECD) administers the grant program, and its commissioner must develop the application process and selection criteria by October 1, 2022. Each municipality that receives a YSC program grant must operate, establish, or demonstrate plans to establish a local YSC program. The act requires the local program to conform to parameters the act sets (see below).

By January 1, 2023, and annually thereafter, the DECD commissioner must award grants to municipalities selected to participate in the amount of $10,000 per participating youth or young adult plus 15% of that amount for program administration expenses. Under the act, the municipalities may use the grants to (1) administer the local YSC program and (2) award a subgrant of up to $10,000 to any participating youth or young adult to support or subsidize participation in program activities.

Relatedly, the act creates a "youth service corps grant program account" as a separate, nonlapsing account within the General Fund. The account must contain any moneys that the law requires to be deposited in it. The DECD commissioner must spend account funds on the YSC program.

The act also establishes annual reporting requirements for participating municipalities and DECD.
EFFECTIVE DATE: July 1, 2022

Participant Eligibility

Under the act, program participants must be youths or young adults age 16 to 24 who are showing signs of disengagement or disconnection from school, the workplace, or the community. The program must focus on youth or young adults involved with the justice system or DCF, in foster care, or experiencing homelessness.

The act requires participation to be by referral only, and referrals must be made by (1) a school official, (2) a juvenile probation officer, (3) the DCF commissioner or her designee, or (4) a community organization employee whom the municipality

or its YSC program administrator designates to make referrals. Each youth or young adult participant must develop an individual success plan to identify education, workforce, or behavioral development goals.

Program Administration

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

Under the act, to support the participants' identified goals, each local YSC program must provide the following:

1. year-long, part-time employment with flexible hours for public or private employers the program administrator screens and approves;
2. community-based service learning projects the program administrator selects;
3. a transition plan for the participant detailing goals and steps to take to accomplish them; and
4. other activities the program administrator approves.

Program administrators must evaluate each youth and young adult participant using performance indicators applicable to them, including education outcomes, career competency development, training completion, and positive behavior changes to measure whether the participant is achieving his or her goals.

Reporting Requirements

Beginning by December 1, 2023, each municipality that received a grant must annually report on its local YSC program to the DECD and DCF commissioners in a form and manner the DECD commissioner determines.

Additionally, the DECD commissioner, in consultation with the DCF commissioner, must annually report on the program, beginning by January 1, 2024, to the Commerce and Children's committees.

§§ 62-64 — INFORMATION ON CHILDREN'S MENTAL HEALTH AND DOMESTIC VIOLENCE

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

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

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

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

2. distribute the document electronically to SDE; and
3. distribute it electronically and in hard copy to DESPP, each municipal police department, and each ambulance company and organization that offers transportation or treatment services to patients under emergency conditions.

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

1. requires state and municipal police officers and emergency medical technicians, including medical responders, to keep copies of the DCF and OVS documents in any vehicle they use to carry out their duties;
2. allows the police officers and emergency medical technicians to provide a copy of the documents to anyone, including a victim's family member, whom the officer or technician determines may benefit from the services or resources described in them; and
3. requires peace officers at the scene of a family violence incident to provide victims with the OVS victim resource document and, if there is a child at the scene, a copy of the DCF children's resources document containing children's mental health resources in the victim's mental health region.

EFFECTIVE DATE: July 1, 2022

§§ 65 & 66 — VICTIM COMPENSATION PROGRAM EXPANSION

Expands the Victim Compensation Program by extending eligibility to victims of (1) child abuse substantiated by DCF and (2) certain other crimes against minors that OVS or a victim compensation commissioner reasonably concludes occurred

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

The act expands compensation eligibility under the program to victims of child abuse substantiated by DCF on or after October 1, 2022, so long as the individual whom DCF determines is responsible is placed on its child abuse and neglect registry. It also requires the DCF or children's advocacy center employee to whom the abuse was disclosed to notify the victim or the victim's parent, guardian, or legal representative about the (1) victim's potential eligibility for the program, (2) program application process, and (3) types and amounts of compensation that may be awarded. Specifically, the employee must notify the person who disclosed the injury (e.g., victim or parent) both verbally and in writing. The act does not specify a time frame within which the employee must make the notification.

Additionally, under existing law, OVS or, on review, a victim compensation commissioner may order compensation to be paid to certain victims (e.g., sexual assault or trafficking victims) if (1) the personal injury has been (a) disclosed to certain professionals, such as a doctor, DCF worker, or guidance counselor or (b) reported in a restraining or civil protection order application that was granted, and (2) the office or commissioner reasonably concludes that the violation occurred. The act expands eligibility under these conditions to victims of the crimes of

commercial sexual abuse of a minor, enticing a minor, obscenity as to a minor, employing or promoting a minor in an obscene performance, and commercial sexual exploitation of a minor.
EFFECTIVE DATE: October 1, 2022

Background — Victim Compensation Program

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

§ 67 — SPECIAL EDUCATION DISABILITY TERMINOLOGY

Requires SDE and boards of education to use "emotional disability" instead of "emotional disturbance" for special education purposes

Beginning July 1, 2022, the act requires SDE and local and regional boards of education to use the term "emotional disability" instead of "emotional disturbance" when administering and providing special education services. It specifies that "emotional disability" under the act has the same meaning as "emotional disturbance" under federal special education law (see *Background* below).
EFFECTIVE DATE: Upon passage

Background — Emotional Disturbance

Federal regulations for the Individuals with Disabilities Education Act (IDEA, 20 U.S.C. § 1400 et seq.) define "emotional disturbance" as a condition exhibiting one or more of the following characteristics over a long period of time to a marked degree and adversely affecting educational performance:

1. an inability to learn that cannot be explained by intellectual, sensory, or health factors;
2. an inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
3. inappropriate types of behavior or feelings under normal circumstances;
4. a general pervasive mood of unhappiness or depression; or
5. a tendency to develop physical symptoms or fears associated with personal or school problems.

The definition also includes schizophrenia. It does not apply to children who are socially maladjusted unless they are determined to have an emotional disturbance as defined above (34 C.F.R. § 300.8).

§ 68 — CHILD AND ADOLESCENT PSYCHIATRY WORKING GROUP

Creates a working group to develop a plan to increase the number of psychiatry residency and child and adolescent psychiatry fellowship placements in the state

The act establishes a 10-member child and adolescent psychiatry working group. The group must develop a plan to increase the number of psychiatry residency and child and adolescent psychiatry fellowship placements in the state. The plan must (1) maximize state and federal funding sources and (2) provide these psychiatry residents and fellows with the opportunity to treat in-state children and adolescents who are uninsured, underinsured, or eligible for benefits under HUSKY B (i.e., the state children's health insurance program).
EFFECTIVE DATE: July 1, 2022

Membership and Administration

The working group consists of the DPH and DSS commissioners, or their designees, and eight appointed members as shown in the table below.

Child and Adolescent Psychiatry Working Group Appointed Members

Appointing Authority	*Appointee Qualifications*
House speaker (2)	One federally qualified health center representative One Public Health Committee member
Senate president pro tempore (2)	One faculty member from an in-state psychiatry residency program One Public Health Committee member
House majority leader (1)	Federally qualified health center representative
Senate majority leader (1)	In-state practicing child and adolescent psychiatrist
House minority leader (1)	Public Health Committee member
Senate minority leader (1)	Public Health Committee member

Under the act, the appointing authorities must make their initial appointments by July 31, 2022, and fill any vacancy.

The House speaker and Senate president pro tempore must each select a co-chairperson from among the working group's members. The chairpersons must schedule the first meeting, which must be held by August 30, 2022.

The Public Health Committee's administrative staff serves in that capacity for the working group.

Reporting Requirement

The act requires the working group to report to the Public Health Committee by January 1, 2023, on its findings and recommendations, including (1) its activities, research findings, and any proposed legislative changes and (2) any potential

funding sources for additional psychiatry residency and child and adolescent psychiatry fellowship placements.

§ 69 — DPH GRANT TO CHILDREN'S HOSPITAL

Allows DPH, within available resources, to award a $150,000 grant in FY 23 to an in-state children's hospital for coordinating a mental and behavioral health training and consultation program; requires the hospital to report on the program

The act allows DPH, within available resources, to issue a $150,000 grant in FY 23 to an in-state children's hospital to coordinate a mental and behavioral health training and consultation program from January 1, 2023, to January 1, 2025. The program must be available to all in-state, practicing pediatricians to help them gain the necessary knowledge, experience, and confidence to effectively treat pediatric mental and behavioral health issues.

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

EFFECTIVE DATE: July 1, 2022

§ 70 — BEHAVIORAL AND MENTAL HEALTH POLICY AND OVERSIGHT COMMITTEE

Establishes a Behavioral and Mental Health Policy and Oversight Committee; requires the committee to evaluate and report on various matters related to the mental health system for children and develop a related strategic plan

The act establishes, within the Legislative Department, a Behavioral and Mental Health Policy and Oversight Committee. The committee's charge is to (1) evaluate the availability and efficacy of prevention, early intervention, and mental health treatment services and options for children (birth to age 18) and (2) make recommendations to the legislature and executive agencies on the governance and administration of the mental health care system for children.

EFFECTIVE DATE: Upon passage

Committee Membership and Administration (§ 70(b)-(f))

Under the act, the committee's membership includes the following officials or their designees:

1. the chairpersons and ranking members of the Appropriations, Children's, Human Services, and Public Health committees;
2. the commissioners of the departments of Children and Families, Correction, Developmental Services, Early Childhood, Education, Insurance, Mental Health and Addiction Services, Public Health, and Social Services;
3. the OHS executive director;

4. the child advocate;
5. the healthcare advocate;
6. the Court Support Services Division executive director;
7. the Commission on Women, Children, Seniors, Equity and Opportunity executive director; and
8. the OPM secretary.

The committee also includes 13 appointed members, as shown in the table below.

Behavioral and Mental Health Policy and Oversight Committee Appointed Members

Appointing Authority	*Appointee Qualifications*
House speaker (3)	One legislator Two providers of mental, emotional, or behavioral health services for children in the state
Senate president pro tempore (3)	One legislator Two representatives of private advocacy groups that provide services to children and families in the state
House majority leader (2)	Two representatives of children's hospitals
Senate majority leader (1)	Representative of public school superintendents in the state
House minority leader (2)	Two representatives of families with children diagnosed with mental, emotional, or behavioral health disorders
Senate minority leader (2)	Two providers of mental or behavioral health services

Lastly, the committee includes, as ex-officio, nonvoting members, one representative from each administrative services organization under contract with DSS to provide services for HUSKY Health recipients.

The act allows the legislative designees or appointees to be legislators. The appointing authority fills any vacancy.

The OPM secretary or his designee serves as a committee co-chairperson. The other co-chairperson must be a legislator, selected jointly by the House speaker and Senate president pro tempore, from among the following members: (1) the legislative committee chairpersons or ranking members (or their designees) or (2) the House speaker's or Senate president pro tempore's appointees. The chairpersons must schedule the first meeting, which must be held by July 3, 2022.

Under the act, committee members serve without compensation except for necessary expenses in performing their duties.

Initial Report (§ 70(g))

The act requires the committee to report certain information by January 1, 2023, to the Appropriations, Children's, Human Services, and Public Health committees

and the OPM secretary.

The committee must report its recommendations for any necessary statutory and budgetary changes in the mental health system of prevention, development, and treatment to accomplish the following:

1. improve children's developmental, mental health, and behavioral health outcomes;
2. improve transparency and accountability for state-funded services for children and youth, emphasizing the committee's identified goals for community-based programs and facility-based interventions; and
3. promote efficient information sharing by state and state-funded agencies to ensure the regular collection and reporting of data on children and families' access to, use of, and benefit from needed services to promote public health and mental and behavioral health outcomes for children, youth, and their families.

The committee's report also must include the following:

1. service gaps the committee identified for children and families involved in the mental health system, and recommendations to address these gaps;
2. strengths and barriers the committee identified that support or impede the mental health needs of children and youth, with specific recommendations for reforms;
3. an examination of how state agencies can work collaboratively through school-based efforts and other processes to improve children's mental health and developmental outcomes;
4. an examination of disproportionate access and outcomes across the mental health care system for children of color;
5. a comparable examination for children with developmental disabilities;
6. a plan to ensure a quality assurance framework, including efficacy and outcome data, for state or private facilities and programs in the mental health care system; and
7. a governance structure for the children's mental health system to best facilitate the state's public policy and health care goals to ensure that all children and families can access high-quality care.

Consultation With and Support From Other Organizations (§ 70(h))

The act requires the committee, before completing its duties, to request consultation with at least one organization that focuses on the quality of children's services or research related to children's well-being, such as The Child Health and Development Institute or Connecticut Voices for Children. It allows the committee to accept administrative support and technical and research assistance from these types of organizations.

The act also requires the committee to collaborate with any results-first initiative implemented pursuant to law. (Generally, results-first is an evidence-based, cost-benefit analysis to evaluate public policy program effectiveness.)

Data Access (§ 70(i))

The act requires that the committee have access to data the state collects on children's behavioral health-related matters, either from the agencies themselves or directly from contracted administrative service organizations, as applicable.

Subcommittees (§ 70(j))

Under the act, the committee must have at least two subcommittees to inform its recommendations. The subcommittees may focus on workforce-related issues, school-based health, prevention, and intermediate or acute care. Each subcommittee must (1) be chaired by a committee member and (2) examine gaps, reimbursement rates, parity in service outcomes, and service efficacy.

Review and Follow-up Reports (§ 70(k))

The act requires the committee to establish a time frame for reviewing and making follow-up reports on the status or progress of the committee's recommendations and activities. These reports must include (1) specific recommendations to improve outcomes related to children's mental, emotional, or behavioral health and (2) a timeline for achieving specific tasks or outcomes.

Strategic Plan (§ 70(l) & (m))

Under the act, the committee must develop a strategic plan integrating the recommendations identified in its initial report. The plan may include short-, medium-, and long-term goals. In developing the plan, the committee must collaborate with any state agency that has responsibilities relating to the mental health system.

The act requires the committee, by August 1, 2023, to report the strategic plan to the Appropriations, Children's, Human Services, and Public Health committees and the OPM secretary. The report must also include (1) an account of progress made toward fully implementing the plan and (2) any recommendations on implementing the plan's identified goals.

§§ 71-73 — ADVERSE DETERMINATION NOTICES

Requires certain information on adverse determination notices to be prominently displayed and approved by the healthcare advocate

By law, health carriers must notify insureds or their representatives of adverse determinations (e.g., benefit denials). The act generally requires certain information contained in the notices to be more prominently displayed and approved by the healthcare advocate.

Existing law requires these adverse determination notices to contain certain information based on the type of denial and determination, including:

1. a statement that the insured may appeal the determination, that appeals are sometimes successful, and other appeal-related information;
2. the insured's right to contact the Office of the Healthcare Advocate at any

time regarding adverse determinations that have been appealed or that are not based on medical necessity; and

3. the insured's right to receive documents related to their adverse determinations.

The act requires the above information to be in language the healthcare advocate approves and prominently displayed on the notice's first page or cover sheet using a call-out box and large or bold text.

EFFECTIVE DATE: January 1, 2023