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May 5th, 2025
3:00 PM – 4:30 PM
Zoom

May TCB School Based Workgroup Agenda

1. **Welcome and Introductions**
    a. Introductions, Ice breaker for the group
2. **TCB Updates**
    a. May TCB Meeting
    b. Legislative updates
    c. Prevention and Services workgroup updates
3. **TCB Strategic Plan**
    a. The workgroup will review the initial proposed measures of success in the school-based section based on priorities of the group.
4. **School Based Health Center Study**
    a. Briefing on Scope
    b. Solicit input on partners, communications to SBHCs, prospective researchers and other feedback
5. **School Behavioral Health Services Recommendation**
    a. Scope Brainstorm Discussion
6. **Services Array Survey Walkthrough**
    a. Purpose

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TCB School-Based Workgroup Meeting Summary
May 5, 2025
3:00-4:30 PM
Web Based Meeting- ZOOM

Attendees:			**TYJI Attendees:**
Elizabeth Connors	Michael Powers	Katie Rudek	Emily Bohmbach
Miriam Miller	Carli Rocha-Reaes	Kristen Parsons	Erika Nowakowski
Ann Gionet	Jimnahs Miller	John Tarka	Jaqueline Marks
Katie Rudek	Kaye Bohannan	Jess Sanders	Stacey Olea
Edith Boyle	Drew Lavalle	Susan Israel	
Christopher Trombly	Heather Dawson	Christine Velasquez	
Jill Farrell	Megan Bourguillon	Lauren Scopaz	
Devana Campbell	Stephanie Bozak	Melanie Wilde-Lane	
Heather Dawon	Shari L Shapiro	Allison Van Etten	

Meeting Objectives:

- TCB Updates
- School Based Health Center Study & School Behavioral Health Services Billing Review
- Services Array Gaps Analysis

Meeting Summary:

1) **TCB Updates**
   a) A TYJI staff member went over the TCB Organizational Structure, which can be found in the 2025-2028 Strategic Plan provided in the meeting materials.
   b) Additionally, a TYJI Staff member provided an overview of the upcoming May TCB meeting, and legislative updates, on HB 6951, HB7109, and HB 7263. All meeting materials can be found in the monthly Meeting Materials folder.
   c) A TYJI Staff member provided updates on the Prevention and Services Workgroup and identified if anyone is interested in joining a workgroup or has additional questions to contact TYJI staff.
   d) Lastly, an overview of the Services section of the strategic plan was given to the workgroup. The workgroup was tasked with reviewing the school-based section of the

plan, and to specifically evaluate the measures of success listed, as the group will have a discussion regarding the initial proposed measures of success and evaluate if the measures can be ranked to identify our priority measurement for 2025, how we plan to measure, and if we have different measures of success that should be added.

2) **School Based Health Center Study & School Behavioral Health Services Billing Review**

a) The school-Based Workgroup Co-chair gave a brief overview of the School Based Workgroup Workplan and went over the definition of School Behavioral Health Services with the group as identified in the plan and gave a brief overview of the two studies identified as priorities in the workplan, which include the School Based Health Center (SBHC) Study, as well as the School Behavioral Health Services Billing Review Recommendation.

b) A brief overview of the SBHC study was provided by the workgroup co-chair. The co-chair shared that the workgroup chairs met with DPH, TYJI Staff and a tri chair to discuss the outline and intent of the study.

i) A representative from DPH added context of the study, stating that DPH funds 91 SBHCs, which is not a representative sample of all SBHCs in the state. The workgroup member added that having information from the study will allow DPH in conjunction with the legislature and TCB to make recommendations holistically on where resources should be used, and with that data look into the expansion of services by looking at the system.

ii) Discussion was had within the workgroup on clarifying the outline of the study and the partners involved. TYJI clarified what would be included in the RFQ for the study, which would be released this summer. Additionally, a member suggested that a presentation on SBHCs to the group would be helpful to level-set.

3) **Services Array Gaps Analysis**

a) A Member from the UConn Innovations Team shared a brief overview of the Services Array Gaps Analysis Survey and shared the next subgroup meeting will be held on 5/13 from 1-2.

i) A TYJI staff member will share out the most recent version of the study and encourage those interested in joining the workgroup to reach out.

Next Meeting: June 2nd, 2025 at 3:00 PM

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TCB School Based Workgroup Meeting

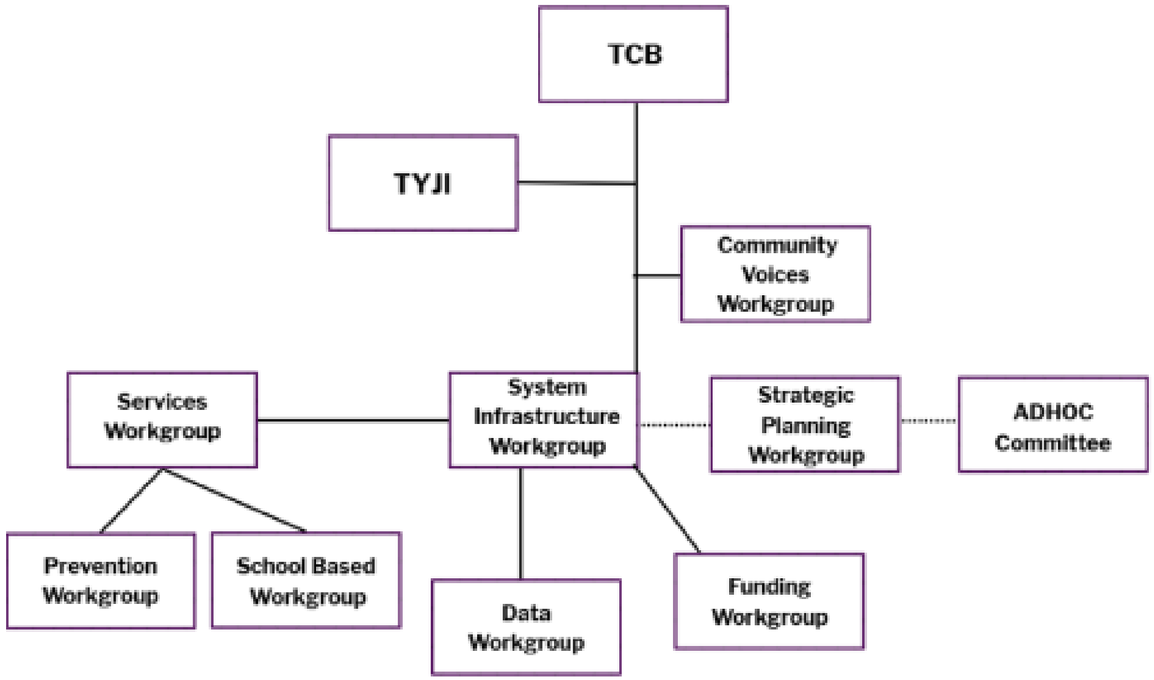
May 5th, 2025

TCB Organizational Structure

Abbreviations

TCB = Transforming Children's Behavioral health Policy and Planning Committee

TYJI = Tow Youth Justice Insitute



The Image above is the TCB's organizational chart, which reflects the workgroups and structure of the committee.

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TCB Monthly Meetings

- TCB Meetings are hybrid and held monthly in the Legislative Office Building (LOB) and on zoom. All meetings are recorded and streamed on the TYJI YouTube Channel and through the Connecticut News Network (CTN)

- Meeting Materials are posted on the TCB's Connecticut General Assembly (CGA) website prior to the Monthly meeting

April and May Meeting Overview:

- In April, the TCB's Community Voices Workgroup (CVW) introduced themselves and presented their workplan to the committee. Additionally, TYJI has contracted with Health Equity Solutions (HES) who introduced themselves to the committee, gave an overview of their scope of work, and level set community engagement terms with the group. Lastly, the committee voted to adopt the 2025-2028 Strategic Plan.

- At the May 14th TCB meeting, HES will conduct a focus group session around transformative engagement with the committee. Additionally, Prevention workgroup co-chairs will present on Prevention terminology and topics. Lastly, Jill Farell from UConn Innovations will provide an update on the Service Array Gaps Analysis.

Legislative Updates

The TCB currently has three bills going through the legislative process, **HB 6951, HB 7109,** and **HB7263.** The bills are linked below.

HB 6951

- Had a public hearing on 2/20 through the Children's Committee, and on 3/12 was sent to the appropriations committee.
- This bill includes the crisis continuum study recommendation, school-based health center study, and funding for mobile crisis recommendation.

HB 7109

- Was referred out of the Children's Committee and to the Human Services Committee, and had a public hearing on 3/6, and filed with legislative commissioner's office on 3/19.
- This bill included our recommendations regarding amending the age of insurance coverage for ABA therapies for individuals with ASD, the UCC Study, IICAPS recommendation, and the design of the CCBHC planning grant.

HB 7263

- Had a public hearing on 4/3 through the Appropriations committee.
- This bill would allow for the Behavioral Health Advocate and two providers of substance use disorder who treat youth to be appointed members of the TCB.
- As of 4/30 TCB Committee Member Howard Sovronsky became the State's Behavioral Health Advocate

Please be on the lookout for any emails from the Tow Youth Justice Institute on any other legislative updates.

Services Workgroup Updates

Services Co-chairs:

Edith Boyle, LCSW, President and Chief Executive Officer, LifeBridge Community Services
Yann Poncin, MD, Associate Professor and Vice Chair of Clinical Affairs in the Child Study Center

Purpose Statement: The Services Workgroup is focused on ensuring statewide and local capacity and awareness to provide a comprehensive range of affordable, integrated, coordinated, and family-centered services to children from birth to age 22, individualized and within the context of their families, caregivers, and communities.

Workgroup Updates:

- The Services workgroup met for the first time in 2025 on April 7th. The group reviewed the draft workplan and received updates from UConn Innovations on the Services Array Survey.
- The next workgroup will be held on May 7th, 2025.

Please reach out for any additional information on workgroups or if you would like be a part of the listserv.

Prevention Workgroup Updates

Prevention Co Chairs:

Ingrid Gillespie, Director of Prevention, Liberation Programs Inc
Pamela Mautte, Director, Alliance for Prevention & Wellness Program of BH Healthcare

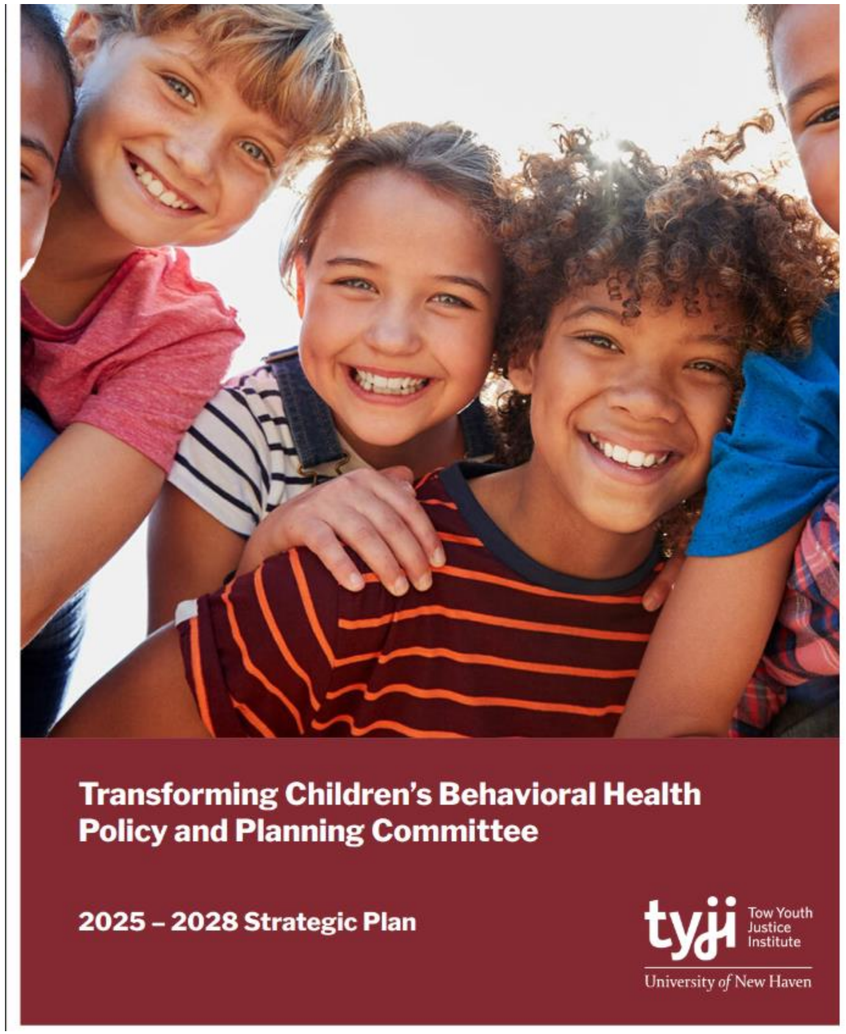
Purpose Statement: The Prevention workgroup is committed to strengthening children's behavioral health prevention services and programming. It will collaborate to identify challenges, examine solutions, and provide advisory recommendations to enhance prevention efforts statewide.

Workgroup Updates:

- The Services workgroup met for the first time in 2025 on April 7th. The group went over the draft workplan and got updates from Uconn Innovations on the Services Array Survey.
- The next workgroup will be held on May 7th, 2025.

Please reach out for any additional information on workgroups or if you would like be a part of the listserv.

2025-2028 Strategic Plan



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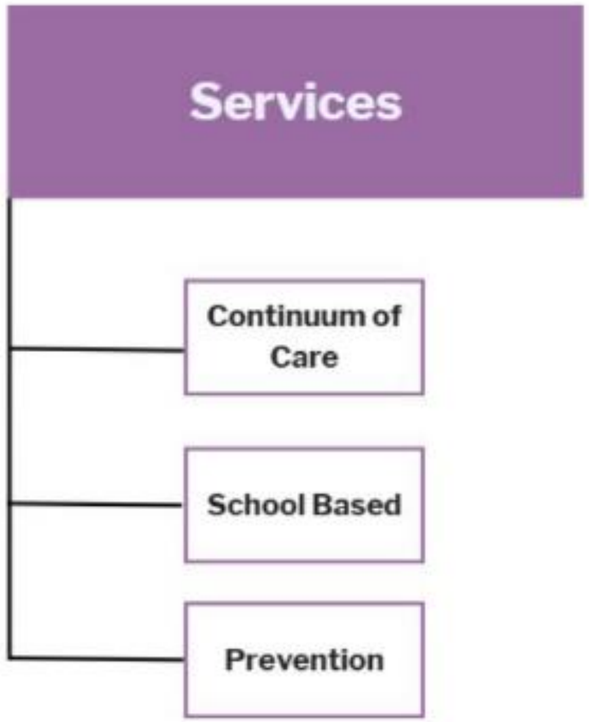
School-Based Behavioral Health Workgroup



The image above reflects the priorities identified within Services. Not all priorities are workgroups within the TCB.

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School-Based Services

Goal: Expand access to high quality school-based behavioral health services for all students in Connecticut.

Partners

- State Departments of: Education, Mental Health and Addiction Services, Public Health and Social Services
- Office of Health Strategy
- National Association of Social Workers - CT Chapter
- CT Association of School Psychologists
- CT School Counselor Association
- Community Child Guidance Clinics
- Commercial insurance providers to address reimbursement challenges
- Association of School Based Health Centers

Information needed

- Data on workforce needs
- Program funding to ensure sustainability
- Data on potential partnerships and resource allocation from Department of Public Health or other agencies
- Reporting requirements for SBHCs

Outputs

- Models to integrate community partners into school based care
- Transparent reporting mechanisms and reporting standards
- Models for integrating prescribers into school-based carelmproved staff retention and job satisfactions
- Funding for sustainability of school-based behavioral health services
- Sustainable systems of collaboration with state agencies

Measures of Success

- Improved school mental health quality
- Increased number of school-community partnerships across the State
- Number of policy and planning conversations and decision incorporating Family and Youth voice

Services-School Based Measures of Success

Goal: Expand access to high quality school-based behavioral health services for all students in Connecticut.

Next Steps

- The 2025-2028 Strategic Plan is located within the School Based shared drive. Please review the plan, specifically the School Based section.

- The workgroup will have a discussion at our next meeting regarding the initial proposed measures of success, evaluate if the measures can be ranked to identify our priority measurement for 2025, how we plan to measure, and if we have different measures of success that should be added.

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TCB School Based Workgroup Glossary of Terms and Acronyms

The TCB Glossary is a living document that contains frequently used phrases and terms. Additional terminology will be added as meetings occur throughout the year.

1. **42 CFR**: Part 2: A federal regulation that protects the privacy of patients with substance use disorders (SUD). Confidentiality protections help address concerns that discrimination and fear of prosecution deter people from entering treatment for SUD.
2. **504:** Section 504 of the Rehabilitation Act and the Americans with Disabilities Act is civil rights law protects individuals with disabilities from discrimination that arise because of their disability. A 504 Service Agreement is considered when a A child has a disability that can limit at least one major life activity, which can include walking, seeing, hearing, speaking, breathing, learning, reading, writing, performing math calculations, taking care of oneself, or performing simple manual tasks. A 504 Service Agreement often contains a list of accommodations and modifications that can assist the child with disabilities in the classroom.
3. **Acute Care:** Medical treatment rendered to individuals whose illnesses or health problems are of short-term or short episodes. Acute care facilities are those hospitals that mainly serve persons with short-term health problems.
4. **Advocacy:** Advocacy means encouraging someone, including legislators, but also the public or individual community members, to take action on an issue that is not currently being considered as legislation by the legislature, or as administrative action by the executive branch. (Compare to "Lobbying" and "Education."
5. **Amendment:** A written proposal to change the language of a CGA bill or resolution, prepared by the Legislative Commissioner's office. Each amendment can be identified as House or Senate "A."
6. **Anorexia Nervosa (also called anorexia):** An eating disorder characterized by low body weight (less than 85 percent of normal weight for height and age), a distorted body image, and an intense fear of gaining weight.
7. **Attention-Deficit/Hyperactivity Disorder (ADHD):** A behavior disorder, usually first diagnosed in childhood, which is characterized by inattention, impulsivity, and, in some cases, hyperactivity.
8. **Autistic Spectrum Disorder (also called autism**): A neurological and developmental disorder that usually appears during the first three years of life. A child with autism appears to live in his/her own world, showing little interest in others, and a lack of social awareness. The focus of an autistic child is a consistent routine and includes an interest in repeating odd and peculiar behaviors. Autistic children often have problems in communication, avoid eye contact, and show limited attachment to others.

9. **Behavioral Health**: A state of mental and emotional being and/or choices and actions that affect wellness. Behavioral health challenges include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicidal ideation, and mental disorders.
10. **Behavioral Health Assessment**: A behavioral health assessment is a comprehensive evaluation of a person's mental and emotional health, including their thoughts, feelings, behaviors, and overall functioning. The assessment uses interviews, questionnaires, and physical exams to diagnose conditions such as anxiety, depression, and cognitive disorders.
11. **Bill Number**: The number given to each CGA bill when it is first introduced in a legislative session. Senate bills are number 1 to 4999; House bills are number 5000 and up.
12. **Bullying:** Bullying is unwanted and aggressive behavior among children in grades kindergarten to twelve, inclusive, that involves a real or perceived power imbalance.
13. **Case Management:** A process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a client's health and human service needs.
14. **Children's Health Insurance Program (CHIP):** A program by which states insure low-income children (aged 19 or younger) who are ineligible for Medicaid but whose families cannot afford private insurance. States receive federal matching dollars to help provide for this coverage
15. **Evidence Based Practices:** Evidence Based Practice in education refers to instructional and school-wide improvement practices that systematic empirical research has provided evidence of statistically significant effectiveness.
16. **Ohio Scales:** Include 40 items that measure the degree of problems a child is currently experiencing (problem severity) and the degree to which a child's problems affect their day-to-day activities (functioning).
17. **Practitioner or Clinician**: A healthcare professional such as a mental health counselor, physician, psychiatrist, psychologist, or nurse who works directly with patients (as opposed to one who does research or theoretical studies).
18. **Co-morbidity:** Having more than one disorder or illness at the same time.
19. **Commitment:** A court order, giving guardianship of a minor to the state department of juvenile justice or corrections. The facility in which a juvenile is placed may be publicly or privately operated and may range from a secure correctional placement between non-secure or staff secure, group home, foster care, or day treatment setting. Involuntary Commitment of an individual to a psychiatric in-patient unit by a psychiatrist after finding patient to be a danger to self or others.
20. **Education:** In the context of policy change, education means informing someone, including legislators, but also the public or individual community members, about facts,

or real-life experience related to a particular issue, without encouraging any particular action on the issue, whether or not that issue is currently being considered, as legislation by the legislature. (Compared to "Advocacy.")

21. **FAPE (Free Appropriate Public Education):** FAPE stands for Free Appropriate Public Education. It's a fundamental right for students with disabilities in the United States, guaranteed by the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act. This means that schools must provide special education and related services, at no cost to the family, to meet the unique needs of students with disabilities and help them benefit from their education.
22. **FERPA (Family Educational Rights and Privacy Act):** Is a U.S federal law that protects the privacy of student education records. It grants parents and eligible students access to their education records, the right to request corrections, and the right to limit disclosure of information. FERPA applies to any educational institution that receives federal funding, including public and most private schools.
23. **Fiscal Analysis, Office of (OFA):** The nonpartisan staff office of the CGA responsible for assisting the legislature in its analysis of tax proposals, the budget, and other physical issues.
24. **Fiscal Note:** Statement prepared by the Office of Fiscal Analysis of the cost for savings resulting from a bill or amendment. Required for every bill or amendment considered by the House or Senate.
25. **Fiscal Year (FY):** The state's budget year which runs from July 1 to June 30.
26. **HIPAA:** HIPAA (The Health Insurance Portability and Accountability Act of 1996) is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient or legal guardian's consent or knowledge.
27. **IDEA:** The Individuals with Disabilities Education Act (IDEA) is a federal law that ensures children with disabilities have access to a free, appropriate public education. It mandates that schools provide special education and related services designed to meet the unique needs of students with disabilities, and it also requires schools to provide an Individualized Education Program (IEP) for each eligible student.
28. **IEP (Individualized Education Program):** An Individualized Education Program (IEP) is a written plan for a student with a disability, created by the Planning and Placement Team (PPT), which includes the student's parents and various professionals (such as administrators, teachers, and therapists). The IEP is reviewed and updated at least annually and outlines the student's current performance, learning needs, required services, their duration, and the individuals responsible for providing these services.
29. **Inpatient Care:** Care for a period of time in a hospital or (psychiatric residential treatment- not technically considered in-patient) facility during which an individual can be closely monitored to provide accurate diagnosis, to help adjust or stabilize

medications, or during an acute episode when a person's mental illness temporarily worsens.

30. **Lobbying:** Communicating directly or soliciting others to communicate with any official or their staff in the legislative or executive branch of government or in a quasi-public agency, for the purpose of influencing any legislative or administrative action. For example, encouraging a legislator or member of their staff to "vote for/against" a particular bill is lobbying. (Compare to "Advocacy.") "Lobbying" does not include (A) communications by or on behalf of a party to a contested case before an executive agency, or a quasi-public agency, (B) communications by vendor acting as a salesperson, and now otherwise trying to influence an administrative action, (C) communications by an attorney made while engaging in the practice of law. (For more, see CGA definition.)
31. **Lobbyist:** Person required to register with the Ethics Commission who spends or is paid at least $2000 a year to influence legislation. Lobbyists are required to wear blue badges stating their names and whom they represent.
32. **Managed Care:** May specify which caregivers the insured family can see and may also limit the number of visits and kinds of services that are covered by insurance. Connecticut is one of a small number of states that does not participate in Medicaid Managed Care.
33. **Medicaid:** A program jointly funded by federal and state governments that provides health care coverage to certain classes of people with limited income and resources. Within federal guidelines, state governments set eligibility standards, determine optional services provided, set reimbursement rates, and administer the program.
34. **Medicare:** A federal government program that provides health insurance coverage to eligible adults aged 65 or older and people with disabilities. It has four parts: Part A, which covers institutional services, including inpatient hospital services, nursing home care, initial home health visits, and hospice care; Part B, which covers physicians and other professional services, outpatient clinic or hospital services, laboratory services, rehabilitation therapy, and home health visits not covered by Part A, among other services; Part C, the Medicare Advantage program, which is managed by private companies for a flat fee per patient per month; and Part D, which began in 2006 and covers medication.
35. **Mental Health:** A state of emotional and psychological well-being in which an individual is able to use his or her cognitive and emotional capabilities, function in society, and meet the ordinary demands of everyday life.
36. **Mental Illness:** A state of emotional and psychological unrest characterized by alterations in thinking, mood, and/or behavior, causing distress and/or impaired functioning.

37. **Motion:** A formal request for particular action. One member must take a motion and another member second for the group to discuss and vote on an issue before the group. Any member can make a motion.
38. **PPT:** Planning and Placement Teams (PPTs) consist of a diverse group of professionals, including an administrator or their designee, special education and regular education teachers, pupil personnel representatives (such as school counselors, social workers, school psychologists, and speech/language pathologists), parents, and, when suitable, the student. Parents can also invite others who might contribute to the decision-making process. PPTs are responsible for reviewing special education referrals, determining eligibility for services, and developing, reviewing, or revising Individual Education Plans as needed.
39. **Public Act:** A "Public Act" in the context of state or federal legislation refers to a law that is intended to apply to the public, as opposed to a private act which is designed for a specific individual or group. Public Acts become part of the statutory code and are accessible to the public. In Connecticut, Public Acts are bills that have been approved by the Connecticut General Assembly, signed into law by the Governor, and filed with the Secretary of the State.
40. **Operationalize:** to put into operation, action, use or implement.
41. **Outpatient:** A patient who receives medical and/or mental health treatment without being admitted to a hospital.
42. **Readings:** A technical term for three stages of a CGA bill's passage. The first reading is the initial committee referral, the second occurs when the bill is reported to the floor and tables for the calendar and printing, and the third when the bill is debated and voted on. At none of the stages is the bills text read aloud.
43. **Restorative Practices:** Restorative practices are methods that prioritize repairing harm and building relationships over punishment, focusing on understanding the impact of actions and fostering responsibility for the harm caused. They aim to create a positive climate where all feel valued and respected.
44. **School Based Health Center (SBHC):** A School Based Health Center (SBHC), as defined in Public Act (PA) 15-59 is a health center that is located in, or on the grounds of, a school facility of a school district or school board or of an Indian tribe or tribal organization, is organized through school, community and health provider relationships, is administered by a sponsoring facility, and provides comprehensive on-site medical and behavioral health services to children and adolescents in accordance with state and local law, including laws relating to licensure and certification.
45. **School Climate:** School climate is the overall quality and character of school life, emphasizing the quality of relationships within the school community. School climate is shaped by the patterns of individuals' experiences in school and reflects the norms, goals,

values, interpersonal relationships, teaching methods, learning processes, leadership practices, and organizational structures within the school community.

46. **School Community:** School community refers to any individuals, groups, businesses, public institutions and nonprofit organizations that are invested in the welfare and vitality of a public school system and the community in which it is located, including, but not limited to, students and their families, members of the local or regional board of education, volunteers at a school and school employees.
47. **School Employee:** School employees include teachers, substitute teachers, administrators, school superintendents, school counselors, school psychologists, social workers, school nurses, physicians, paraeducators or coaches employed by a local or regional board of education. This also includes any other individuals who, in the course of their duties, have regular contact with students and provide services to or on behalf of students enrolled in a public school, under a contract with a local or regional board of education.
48. **School Environment**: School environment encompasses any school-sponsored or school-related activities, functions, or programs, whether they occur on or off school grounds. This includes locations such as school bus stops, school buses, or other vehicles owned, leased, or utilized by a local or regional board of education. Additionally, it may cover other activities, functions, or programs outside of school-sponsored or school-related events if bullying during these occasions adversely affects the school environment.
49. **Second:** To endorse a motion made by another member. Required for further consideration of the motion. Short session: The three-month CGA session held during even-numbered years.
50. **Social Emotional Learning (SEL):** Social-Emotional Learning (SEL) is a process where individuals develop the skills to understand and manage their emotions, set and achieve goals, feel and show empathy, and build positive relationships. SEL helps individuals build and maintain positive relationships, control strong emotions, and express empathy.
51. **Special Education:** Special education provides individualized instruction and support services for students with disabilities, tailored to their unique needs. It's a process that aims to make learning accessible and to help students with disabilities reach their full potential.
52. **Statute:** Another name for a law. “The statutes” are the General Statutes of Connecticut.
53. **Supplemental Security Income (SSI):** A disability program of the Social Security Administration.
54. **Substance Abuse and Mental Health Services Administration (SAMHSA):** The mission of SAMHSA is to provide, through the U.S. Public health Services, a national focus for the Federal effort to promote effective strategies for the prevention and treatment of addictive and mental disorders. SAMHSA is primarily a grant-making

organization, promoting knowledge and scientific state-of-the art practice. SAMHSA strives to reduce barriers to high quality, effective programs and services for individuals who suffer from, or are at risk for, these disorders, as well as for their families and communities

General Assembly

Raised Bill No. 6951

January Session, 2025

LCO No. **4625**

Referred to Committee on COMMITTEE ON CHILDREN

Introduced by:
(KID)

AN ACT CONCERNING CHILDREN'S BEHAVIORAL HEALTH SERVICES.

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

Section 1. (*Effective July 1, 2025*) (a) The Transforming Children's Behavioral Health Policy and Planning Committee established pursuant to section 2-137 of the general statutes shall conduct a study concerning existing behavioral health services for children and anticipated demand for such services in the future. Such study shall include, but not be limited to, (1) the rates of utilization of the United Way of Connecticut 2-1-1 Infoline program, 9-8-8 National Suicide Prevention Lifeline, mobile crisis intervention services, urgent crisis centers, as defined in section 19a-179f of the general statutes, subacute crisis stabilization centers and hospital emergency departments for such services, (2) outreach and marketing strategies utilized by the service providers listed in subdivision (1) of this section, (3) common sources of patient referrals to such service providers, (4) the allocation of state and other financial resources to such service providers, and (5) the anticipated demand for behavioral health services for children into the future.

(b) Not later than January 1, 2026, the Transforming Children's Behavioral Health Policy and Planning Committee shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to developmental services, public health and children. Such report shall include an analysis of (1) data collected in conducting the study required pursuant to subsection (a) of this section, and (2) recommendations to improve the delivery of behavioral health services for children and meet anticipated demand for such services into the future.

Sec. 2. (*Effective July 1, 2025*) (a) The Transforming Children's Behavioral Health Policy and Planning Committee established pursuant to section 2-137 of the general statutes, shall (1) in collaboration with a state-wide association of school-based health centers, develop a survey for administration at such centers that is designed to obtain information concerning existing data collection practices and the anticipated challenges and opportunities presented by the implementation of more comprehensive data collection systems at such centers, and (2) in collaboration with the Commissioner of Public Health, develop appropriate reporting requirements for school-based health centers to determine and respond to the needs of school-based health centers. The committee may contract with a consultant to develop the survey required pursuant to this subsection.

(b) Not later than January 1, 2026, the Transforming Children's Behavioral Health Policy and Planning Committee shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health. Such report shall include, but need not be limited to, the survey and reporting requirements developed pursuant to subsection (a) of this section.

Sec. 3. (*Effective from passage*) The sum of eight million six hundred thousand dollars is appropriated to the Department of Children and

Families from the General Fund, for the fiscal year ending June 30, 2026, for mobile crisis intervention services.

Sec. 4. (*Effective from passage*) The sum of eight million six hundred thousand dollars is appropriated to the Department of Children and Families from the General Fund, for the fiscal year ending June 30, 2027, for mobile crisis intervention services.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2025*	New section
Sec. 2	*July 1, 2025*	New section
Sec. 3	*from passage*	New section
Sec. 4	*from passage*	New section

Statement of Purpose:

To (1) require the Transforming Children's Behavioral Health Policy and Planning Committee to conduct a study concerning behavioral health services for children and develop a survey and reporting requirements for school-based health centers, and (2) appropriate the sum of eight million six hundred thousand dollars in the fiscal years ending June 30, 2026, and June 30, 2027, to the Department of Children and Families for mobile crisis intervention services.

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

General Assembly

Raised Bill No. 7109

January Session, 2025

LCO No. **5571**

Referred to Committee on HUMAN SERVICES

Introduced by:
(HS)

AN ACT CONCERNING MEDICAID COVERAGE FOR APPLIED BEHAVIOR ANALYSIS SERVICES AND IMPLEMENTING CERTAIN RECOMMENDATIONS OF THE TRANSFORMING CHILDREN'S BEHAVIORAL HEALTH POLICY AND PLANNING COMMITTEE.

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

Section 1. (NEW) (*Effective July 1, 2025*) (a) As used in this section and section 2 of this act, "applied behavior analysis" has the same meaning as provided in section 38a-488b of the general statutes, as amended by this act. The Commissioner of Social Services shall expand access to applied behavior analysis services by (1) within available appropriations, increasing Medicaid rates of payment for supervision, assessment and direct services by board-certified behavior analysts, (2) providing coverage under the HUSKY B health program, as defined in section 17b-290 of the general statutes, for applied behavior analysis services, including, but not limited to, for children with autism spectrum disorder, (3) providing Medicaid coverage for caregiver training utilizing applied behavior analysis, and (4) standardizing codes used to describe applied behavior analysis services for the purpose of Medicaid payment by utilizing codes used by commercial insurers and

Medicaid programs in other states.

(b) Not later than December 1, 2025, the commissioner shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to human services. The commissioner's report shall include, but not be limited to, (1) progress made in expanding access to applied behavior analysis services pursuant to subsection (a) of this section, and (2) recommendations concerning any additional state appropriations needed to support access to applied behavior analysis.

Sec. 2. (*Effective from passage*) Not later than September 1, 2025, the Office of Early Childhood and the Department of Social Services, in consultation with the Autism Spectrum Disorder Advisory Council established pursuant to section 17a-215j of the general statutes, shall make recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to human services and public health concerning a statutory, regulatory and Medicaid reimbursement framework for the delivery of applied behavior analysis services and related services to children by community-based service organizations. Recommendations shall address, but need not be limited to: (1) Any current legislative and regulatory framework that may be applicable to such services, (2) the need for comprehensive background checks for individuals in community-based service organizations who deliver such services to children, (3) the need for an oversight structure that can assure the safety and quality of services to a highly vulnerable population, and (4) a rate-setting structure to ensure adequate Medicaid reimbursement rates to ensure reasonably prompt access to such services for children and families.

Sec. 3. (*Effective July 1, 2025*) (a) As used in this section, "Certified Community Behavioral Health Clinics Planning Grant" means a grant program funded by the federal Substance Abuse and Mental Health Services Administration to support state-certified behavioral health

clinics.

(b) The Commissioner of Social Services, in consultation with the Commissioners of Mental Health and Addiction Services and Children and Families, shall include in the Certified Community Behavioral Health Clinics Planning Grant support for development of: (1) Reimbursement for acuity-based care coordination service to improve behavioral outcomes for children, (2) a value-based payment model that provides financial incentives to providers when outcomes improve for children in their care and holds them accountable for poor outcomes, and (3) a system to help providers and clients better navigate behavioral health care resources and requirements.

(c) Not later than September 1, 2025, the Commissioner of Social Services shall file a report, in accordance with the provisions of section 11-4a of the general statutes, with the joint standing committees of the General Assembly having cognizance of matters relating to children, human services and public health on the status of the planning grant and any benefits of changes made to the grant pursuant to subsection (b) of this section.

Sec. 4. (NEW) (*Effective July 1, 2025*) (a) As used in this section, "Intensive In Home Child and Adolescent Psychiatric Services", or "IICAPS", means in-home psychiatric treatment administered by the Yale Child Study Center at the Yale School of Medicine for families with children or adolescents who have serious emotional disturbances, and are at risk for hospitalization.

(b) The Commissioner of Social Services shall consult with the Yale Child Study Center to review IICAPS and other evidence-based alternatives that focus on delivering positive outcomes for children with behavioral health issues in a sustainable manner while considering the needs and time demands on children and families enrolled in the center's IICAPS program. Not later than October 1, 2025, the commissioner shall report, in accordance with the provisions of section

11-4a of the general statutes, the results of the review to the Transforming Children's Behavioral Health Policy and Planning Committee established pursuant to section 2-137 of the general statutes. The report shall include recommendations concerning IICAPS models that may be used to deliver Medicaid-funded behavioral health care in the state.

(c) The Transforming Children's Behavioral Health Policy and Planning Committee, within available appropriations, may contract with the Yale Child Study Center to determine what additional federal funding and reimbursements may be available for IICAPS model development and to conduct a randomized trial of the Yale Child Study Center model to determine whether it may qualify federally as an evidence-based treatment program.

Sec. 5. Subdivision (4) of subsection (a) of section 38a-514b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(4) "Behavioral therapy" means any interactive behavioral therapies derived from evidence-based research and consistent with the services and interventions designated by the Commissioner of Social Services pursuant to subsection (e) of section 17a-215c, including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with autism spectrum disorder, that are: (A) Provided to children **[**less than twenty-one**]** under twenty-six years of age; and (B) provided or supervised by (i) a licensed behavior analyst, (ii) a licensed physician, or (iii) a licensed psychologist. For the purposes of this subdivision, behavioral therapy is "supervised by" such licensed behavior analyst, licensed physician or licensed psychologist when such supervision entails at least one hour of face-to-face supervision of the autism spectrum disorder services provider by such licensed behavior analyst, licensed physician or licensed psychologist for each ten hours of behavioral therapy provided by the supervised provider.

Sec. 6. Subdivision (4) of subsection (a) of section 38a-488b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(4) "Behavioral therapy" means any interactive behavioral therapies derived from evidence-based research and consistent with the services and interventions designated by the Commissioner of Social Services pursuant to subsection (e) of section 17a-215c, including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with autism spectrum disorder, that are: (A) Provided to children **[**less than twenty-one**]** under twenty-six years of age; and (B) provided or supervised by (i) a licensed behavior analyst, (ii) a licensed physician, or (iii) a licensed psychologist. For the purposes of this subdivision, behavioral therapy is "supervised by" such licensed behavior analyst, licensed physician or licensed psychologist when such supervision entails at least one hour of face-to-face supervision of the autism spectrum disorder services provider by such licensed behavior analyst, licensed physician or licensed psychologist for each ten hours of behavioral therapy provided by the supervised provider.

Sec. 7. (*Effective July 1, 2025*) (a) As used in this section, "urgent crisis center" has the same meaning as provided in section 19a-179f of the general statutes. The Commissioner of Health Strategy, in consultation with the Insurance Commissioner and the Commissioner of Children and Families, shall review private health insurance coverage for treatment of children at urgent crisis centers.

(b) Not later than October 1, 2025, the Commissioner of Health Strategy shall file a report, in accordance with the provisions of section 11-4a of the general statutes, with the Transforming Children's Behavioral Health Policy and Planning Committee established pursuant to section 2-137 of the general statutes. The report shall include the commissioner's analysis of claims data concerning private health insurance coverage of urgent crisis center services and

recommendations to improve affordable access to such services.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2025*	New section
Sec. 2	*from passage*	New section
Sec. 3	*July 1, 2025*	New section
Sec. 4	*July 1, 2025*	New section
Sec. 5	*January 1, 2026*	38a-514b(a)(4)
Sec. 6	*January 1, 2026*	38a-488b(a)(4)
Sec. 7	*July 1, 2025*	New section

Statement of Purpose:

To expand coverage under the state medical assistance program for applied behavior analysis services and implement certain recommendations of the Transforming Children's Behavioral Health Policy and Planning Committee.

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

General Assembly

Raised Bill No. 7263

January Session, 2025

LCO No. **6775**

Referred to Committee on APPROPRIATIONS

Introduced by:
(APP)

AN ACT CONCERNING THE TRANSFORMING CHILDREN'S BEHAVIORAL HEALTH POLICY AND PLANNING COMMITTEE.

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

Section 1. Subsection (b) of section 2-137 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2025*):

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

(1) The chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services, children and appropriations and the budgets of state agencies, or their designees;

(2) Three appointed by the speaker of the House of Representatives, one of whom shall be a member of the General Assembly and two of whom shall be providers of behavioral health services for children in the state;

(3) Three appointed by the president pro tempore of the Senate, one

of whom shall be a member of the General Assembly and two of whom shall be representatives of private advocacy groups that provide services for children and families in the state;

(4) (A) Two appointed by the chairperson of the committee selected by the speaker of the House of Representatives pursuant to subsection (e) of this section, one of whom shall be a child or youth advocate, **[**; and**]** (B) two appointed by the chairperson of the committee selected by the president pro tempore of the Senate pursuant to subsection (e) of this section, one of whom shall be a child or youth advocate, and (C) two jointly appointed by the three chairpersons of the committee, as described in subsection (e) of this section, who shall be providers of substance abuse treatment services to young adults;

(5) Two appointed by the majority leader of the House of Representatives, who shall be representatives of children's hospitals;

(6) One appointed by the majority leader of the Senate, who shall be a representative of public school superintendents in the state;

(7) Two appointed by the minority leader of the House of Representatives, who shall be representatives of families with children who have been diagnosed with behavioral health disorders;

(8) Two appointed by the minority leader of the Senate, who shall be providers of behavioral health services;

(9) Two jointly appointed by the chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies, each of whom shall be a representative of one of the two federally recognized Indian tribes in the state;

(10) The Commissioners of Children and Families, Correction, Developmental Services, Early Childhood, Education, Insurance, Mental Health and Addiction Services, Public Health and Social

Services, or their designees;

(11) The Commissioner of Health Strategy, or the commissioner's designee;

(12) The Child Advocate, or the Child Advocate's designee;

(13) The Healthcare Advocate **[**, or the Healthcare Advocate's designee**]** and the Behavioral Health Advocate, or their designees;

(14) The executive director of the Court Support Services Division of the Judicial Branch, or the executive director's designee;

(15) The executive director of the Commission on Women, Children, Seniors, Equity and Opportunity, or the executive director's designee;

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

(17) One representative from each administrative services organization under contract with the Department of Social Services to provide such services for recipients of assistance under the HUSKY Health program, who shall be ex-officio, nonvoting members.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2025*	2-137(b)

Statement of Purpose:

To add members to the Transforming Children's Behavioral Health Policy and Planning Committee.

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

Transforming Children's Behavioral Health Policy and Planning Committee

2025 LEGISLATIVE RECOMMENDATIONS IN BRIEF

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2025 TCB RECOMMENDATIONS *Note: Recommendations were revised following the January TCB Meeting.*		
Children's Medicaid Behavioral Health Reimbursement Rate Recommendations	1. It is recommended that effective October 1st, 2025, the legislature and the Governor should adequately fund the Department of Social Services to implement an increase of Children's Medicaid behavioral health reimbursement rates based on access needs. The Children's Medicaid reimbursement rate increase should include: a. Adjustment to meet peer-state benchmark rates for children's behavioral health where an applicable benchmark is available, and funding is needed to address access issues. Where a benchmark rate is not available, DSS should recommend a methodology for equitably distributing rate increases to address any access issues/needs. 2. The Department of Social Services should conduct an additional Medicaid Rate Study that specifically evaluates children's behavioral health and compares codes to peer states. The report shall describe how Medicaid investments are reducing the number of codes remaining below the benchmark and evaluating access needs. This study should report the following to the TCB by October 1st, 2025: i. The breakdown of children's behavioral health spend, and where clinic codes are located, ii. After each investment to children's behavioral health (FY '25, '26), The Department of Social Services should evaluate if CT is closer to peer	Fiscal Impact/ Children's Committee

	state benchmarks on code basis and total spending amount, and iii. Identify the proportion of the system that was not matched in the Phase 1 Medicaid Rate Study and provide the TCB a set of recommendations regarding how to approximate access needs for those codes. 3. It is recommended that effective July 1, 2025, the Department of Children and Families should sustain 24/7 mobile crisis expansion initially funded through ARPA. 4. The Department of Social Services should promote Medicaid and commercial billing for UCC services by refining the interim model and rates established for UCCs (as needed) and report on provider billing status under Medicaid to the TCB by Oct 1st , 2025. 5. The Office of Health Strategy (OHS) should submit to the TCB a report on any updates in commercial coverage of UCCs, including changes to plans and contracts, and claims data. The report should be submitted to the TCB by Oct 1st, 2026.	
Workforce Stabilization Recommendations	1. It is recommended that the Department of Social Services conduct a feasibility determination and fiscal analysis to estimate adding a billing code to help off-set initial costs for on-boarding and training clinical staff in evidence-based models, before they can bill for services (e.g. "observation and direction"). This should include: a. Potential Medicaid reimbursement for training and ramp-up, where extensive	Children's Committee

	clinical training in an evidence-based model is needed before billing can occur. b. Feasibility assessment and fiscal analysis estimate should be submitted no later than October 1st, 2025. 2. The Department of Social Services should include as part of the Certified Community Behavioral Health Clinics (CCBHCs) planning and designing grant the following: a. the development of separately payable acuity-based care coordination service to improve outcomes of children, b. a value-based payment model that holds providers accountable and rewards them for improved outcomes, c. and navigation support. 3. It is recommended that the Department of Social Services and Intensive In Home Child and Adolescent Psychiatric Services (IICAPS) Model Development and Operations (MDO) at the Yale Child Study Center, review and design levels of the IICAPS model for consideration. This should be reported back to the TCB by October 1st, 2025. a. Such model should consider the needs and time-demands placed on families and children, and the ability to deliver positive outcomes in a sustainable manner. 4. It is recommended that TCB contract with IICAPS Model Development and Operations (MDO) at the Yale Child Study Center to a. determine what additional federal funding and reimbursements may be available to IICAPS MDO and the	

	IICAPS network as an evidence-based/promising practice treatment program, and if determined prudent, b. conduct a randomized controlled trial (RCT) of IICAPS for the purpose of qualifying IICAPS federally as an evidence-based treatment program. Interim recommendations to TCB by October 1st, 2025.	
ASD Recommendation	1. The TCB recommends an amendment to Sec. 38a-514b (group coverage) and Sec. 38a-488b (individual coverage) of the general statues section to strike through the age of insurance coverage of ABA from 21 to 26, effective January 1st, 2026.	*Insurance*
Continuum of Crisis Services Study Recommendation	1. It is recommended that TCB conduct a study to review utilization and anticipated demand of the children's BH crisis continuum, which includes 211/988, mobile crisis, Urgent Crisis Centers (UCCs), Sub-Acute Crisis Stabilization, and ED, to assess and advance optimal capacity utilization. a. Studies should include current utilization of services, marketing efforts, outreach strategies, referral pathways, and resource allocation. b. TCB should submit a report of recommendations by November 1st, 2025.	Children's Committee
School-Based Health Center Study Recommendations	1. It is recommended that TCB contract with an outside entity to conduct a School Based Health Center (SBHC) study for a. Developing and administering a survey to better understand current data collection practice and the anticipated challenges and opportunities	Children's Committee

	in implementing a more robust data and QI system. b. Identifying effective reporting standards for SBHC's to report to the Department of Public Health (DPH). c. The study will be designed and piloted in collaboration with the Department of Public Health (DPH) and the department of Children and Families (DCF). d. A standardized definition of SBHCs. 1. It is recommended that all School Based Health Centers (SBHCs) report to DPH the following effective January 1st, 2026, annually thereafter a. Establish comprehensive reporting across all SBHCs to inform targeted investment by utilizing reporting mechanisms outlined in the study above.	
School Health Services Recommendation	1. A review of Medicaid and private insurance billing codes (e.g behavioral health services provided and billed within schools) to ensure non-duplicative billing and opportunities to fully claim reimbursement for services provided. ***Note: This language is pending.***	Children's Committee

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Autism Spectrum Disorder (ASD) Recommendation

Background

The prevalence of children with Autism Spectrum Disorder (ASD) continues to increase nationwide, yet treatment and necessary services remain costly, and the costs can vary across insurance coverage. Young adults with autism spectrum disorder (ASD) in Connecticut face a critical gap in access to necessary behavioral health treatment services, specifically Applied Behavior Analysis (ABA), due to current insurance coverage up to age 21. This creates a critical gap in care for individuals over the age of 21, disrupting therapeutic progress and hindering long-term development. This gap exists even though both state and federal law recognize the importance of supporting individuals with disabilities in their development and pursuit of their full potential. Connecticut recognized ABA therapy as a crucial, evidence-based treatment for ASD when it enacted age limits for coverage under CGS §§ 38a-514b and 38a-488b in 2015. This recognition highlights the importance of ABA and the financial burden it places on families.

Facts

- The Centers for Disease Control and Prevention (CDC), estimates 1 in 36 children nationwide have ASD. When applied to Connecticut's 2020 population census data, this suggests approximately 20,481 youth. Survey data from Connecticut parents report rates above the national average.
- Despite young adults with ASD being eligible to remain on their parents' insurance until age 26 and being able to access special education services up to age 22, Connecticut law only mandates insurance coverage for ASD behavioral health therapy until age 21. This creates a critical gap in care for individuals above the age of 21.
- Roughly 5% of children between the ages of 3- and 17-years old with public insurance have ASD.
- Currently in Connecticut, state insurance laws only require insurance coverage for those utilizing Applied Behavioral Analysis (ABA) services up to 21 years of age, yet adolescents are covered on their parent's insurance until age 26.
- Relatedly, students with ASD and other disabilities are eligible for special education services until 22 years of age.

- The high prevalence (97%) of co-occurring health conditions among children with ASD on public insurance emphasizes the need for continuous, comprehensive care, including consistent access to ABA.

TCB Recommendation

1. The TCB recommends an amendment to Sec. 38a-514b (group coverage) and Sec. 38a-488b (individual coverage) of the general statues section to strike through the age of insurance coverage of ABA from 21 to 26, effective January 1, 2026.

Impact of Recommendation

- **Ensure Continuity of Care**: Prevent a disruptive loss of essential ABA services for young adults with ASD during a critical transitional period.
- **Improve Long-Term Outcomes**: Support continued progress in communication, social skills, and adaptive behavior, leading to greater independence and improved quality of life.
- **Reduce Financial Burden**: Alleviate the significant out-of-pocket expenses families currently face when seeking ABA therapy for young adults.
- **Promote Health Equity**: Increase access to affordable, quality healthcare, addressing disparities faced by individuals with ASD and their families.

Conclusion

The enaction of the TCB Autism Spectrum Disorder (ASD) recommendation will result in a significant number of young adults sustaining coverage without paying large amounts out of pocket. The accompanying access, affordability, and quality of health care services will result in positive health outcomes for individuals with ASD that they previously lost access to at the age of 21.

AUTISM SPECTRUM DISORDER RECOMMENDATION

The prevalence of autism spectrum disorder (ASD) among children has been steadily rising in recent years.

According to the CDC, 1 in 36 children are diagnosed with ASD, with prevalence rising over the past decade.

Approximately 20,481 youth in Connecticut are estimated to have ASD.

Rising ASD prevalence is met with costly treatment and inconsistent insurance coverage, creating significant access barriers..

Roughly 5% of children between the ages of 3- and 17-years old with public insurance have ASD.

Connecticut mandates behavioral health therapy coverage only until 21, while federal law allows young adults with ASD to remain on parental insurance until 26 and access special education until 22.

This gap has significant consequences, as evidenced by:

97% of children with ASD on public insurance have co-occurring health conditions.

The TCB ASD recommendation aims to address the gap in insurance coverage for young adults with ASD. Its implementation could allow individuals to maintain coverage, potentially improving access to and affordability of healthcare services.

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Children's Behavioral Health Services Recommendation

Background

Underfunding of Children's Behavioral Health Services Is Creating a Looming Crisis. In recent years, there has been an increased demand for behavioral health treatment and access to these related services which has resulted in an increase in behavioral health disparities. Relatedly, Medicaid reimbursement rates in Connecticut do not correspond to the necessary funds needed, resulting in significant gaps in services. If unaddressed, the continued underfunding of Medicaid and low reimbursement rates will exacerbate existing challenges.

Data

Increased Demand for services

Behavioral health disparities are on the rise, leading to greater demand for treatment.

- Nationally, 1 in 10 children on Medicaid utilize behavioral health services, accounting for 1/3 of all costs for children in Medicaid.
- According to the CDC's *Youth Risk Behavior Survey*, a growing number of adolescents experience poor indicators of mental health and thoughts of suicide.
- In Connecticut, 21% of children ages 0-17 are on Medicaid (742,877 children total), and 42% of them live in poverty or low-income households.
- Untreated mental illness results in significant costs to the state in other areas, such as:
- Increased Emergency Room Visits: Individuals experiencing mental health crises often end up in emergency rooms, which are a far more expensive setting for care than outpatient mental health services.
- Increased Hospitalizations: Untreated mental illness can lead to psychiatric hospitalizations, further straining the healthcare system and driving up costs.

Reimbursement Rates Significantly Below Benchmarks

- The Department of Social Services (DSS) *Phase 1 Report: Studies of Medicaid Rates of Reimbursement* in 2024, compared Connecticut to five other states (New York, Maine, New Jersey, Massachusetts, and Oregon).
- The report revealed that several Medicaid reimbursement rates in Connecticut are significantly below benchmarks established by Medicare and comparable state Medicaid programs.
- Behavioral health services show the most significant gaps, with Medicaid reimbursement rates in Connecticut averaging only 62.3% of the five-state comparison rate.

TCB Recommendations

Recommendation 1: It is recommended that effective October 1st, 2025, the legislature and the Governor should adequately fund the Department of Social Services to implement an increase of Children's Medicaid behavioral health reimbursement rates based on access needs. The Children's Medicaid reimbursement rate increase should include:

1. Adjustment to meet peer-state benchmark rates for children's behavioral health where an applicable benchmark is available, and funding is needed to address access issues. Where a benchmark rate is not available, DSS should recommend a methodology for equitably distributing rate increases to address any access issues/needs.

Recommendation 2: The Department of Social Services should conduct an additional Medicaid Rate Study that specifically evaluates children's behavioral health and compares codes to peer states. The report shall describe how Medicaid investments are reducing the number of codes remaining below the benchmark and evaluating access needs. This study should report the following to the TCB by October 1st, 2025:

1. The breakdown of children's behavioral health spend, and where clinic codes are located,

2. After each investment to children's behavioral health (FY '25, '26), The Department of Social Services should evaluate if CT is closer to peer state benchmarks on code basis and total spending amount, and
3. Identify the proportion of the system that was not matched in the Phase 1 Medicaid Rate Study and provide the TCB a set of recommendations regarding how to approximate access needs for those codes.

Recommendation 3: It is recommended that effective July 1, 2025, the Department of Children and Families should sustain 24/7 mobile crisis expansion initially funded through ARPA.

Recommendation 4: The Department of Social Services should promote Medicaid and commercial billing for UCC services by refining the interim model and rates established for UCCs (as needed) and report on provider billing status under Medicaid to the TCB by Oct 1st, 2025.

Recommendation 5: The Office of Health Strategy (OHS) should submit to the TCB a report on any updates in commercial coverage of UCCs, including changes to plans and contracts, and claims data. The report should be submitted to the TCB by Oct 1st, 2026.

Impact of Increased Medicaid Reimbursement:

- Improved Access: Higher rates will enable providers to expand services and reach more children, particularly in underserved communities.
- Enhanced Quality: Providers can invest in quality improvement, including hiring more staff, upgrading facilities, and implementing new programs.
- Crisis Services: Sustainable funding for mobile crisis expansion is critical for providing timely community-based interventions.

Conclusion

Investing in children's behavioral health through increased Medicaid reimbursement rates is not just a matter of healthcare policy – it is a moral and economic imperative. By taking immediate action to address these chronically low rates, Connecticut can ensure that all

children, regardless of their socioeconomic background, have access to the quality mental health care they need to thrive. Failure to act will only exacerbate the current challenges, leading to poorer outcomes for children and higher costs for the state. This investment will improve the lives of Connecticut's most vulnerable young people and strengthen the state's future.

CHILDREN'S MEDICAID BEHAVIORAL HEALTH REIMBURSEMENT RATE RECOMMENDATION

The CDC's Youth Risk Behavior Survey reveals a concerning trend: more adolescents are reporting poor mental health and suicidal thoughts, with rising behavioral health disparities driving increased demand for treatment.

1 in 10 children on Medicaid use behavioral health services but account for 1/3 of all costs for children in Medicaid.

of children in CT are on Medicaid.

42% of them live in poverty or low-income households.

As the DSS Phase 1 Report (2024) indicates, Connecticut's Medicaid reimbursement rates are well below the average of five comparable states (NY, ME, NJ, MA, OR).

Behavioral health services are the most underfunded, averaging only 62.3% of the five-state comparison rate.

The Cost of Underfunded System

Without access to treatment, costs rise in other areas:

- Treating mental health crises in emergency rooms is a far more costly approach than providing preventative outpatient care.
- Lack of early intervention increases psychiatric admissions, straining healthcare systems.

Increasing Medicaid reimbursement rates for children's behavioral health is a critical policy consideration with both ethical and economic implications. Addressing the current funding shortfall is essential to ensuring equitable access to necessary mental health services for all children. Failure to do so is projected to negatively impact child well-being and increase long-term costs for the state.

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Continuum of Crisis Services Study Recommendation

Background

Connecticut's children deserve a robust and accessible behavioral health crisis response system. While the state has made strides in mobile crisis services, increasing demand and the complexity of children's behavioral health needs require a comprehensive understanding of the entire crisis continuum. This understanding is crucial for effective resource allocation, timely intervention, and ultimately, improving outcomes for children in crisis. The findings of this study will be the cornerstone for policy discissions that protect children and improve system performance.

Connecticut is experiencing a surge in demand for children's behavioral health services. Strong community supports with accessible pathways, can prevent escalation that would require utilization of crisis and/or inpatient services.

Without effective community-based crisis options, families are forced to rely on Emergency Departments that are not fit to offer developmentally appropriate setting for children experiencing a behavioral health crisis. By strengthening community-based crisis options, we can reduce the reliance on EDs and ensure children receive appropriate care in the right setting.

Facts

- Data from Mobile Crisis Intervention Services Fiscal Year 2024 Annual Report revealed Mobile Crisis services responded to 11,346 episodes of care, serving 8,428 Children.
- Data from 2024 indicates that 95.7% of children served in UCC's returned to their homes and communities, and that 49.1% of families indicated that they would have gone to the ED if not for the UCC option.

TCB Recommendation

Recommendation 1: It is recommended that TCB conduct a study to review utilization and anticipated demand of the children's BH crisis continuum, which includes 211/988, mobile crisis, Urgent Crisis Centers (UCCs), Sub-Acute Crisis

Stabilization, and ED, in order to assess optimal capacity utilization and decisions for which services will be utilized.

a. Studies should include current utilization of services, marketing efforts, outreach strategies, referral pathways, and resource allocation.
b. TCB should submit a report of recommendations by November 1st, 2025.

Impact of Study

Analyze current crisis services:

- Current utilization of 211/988, mobile crisis, Urgent Crisis Centers (UCCs), sub-acute crisis stabilization, and EDs for behavioral health crises.
- The effectiveness of existing marketing and outreach strategies for crisis services.
- Referral pathways to identify bottlenecks and improve care coordination.

Project: Future demand for crisis services to proactively plan for resource needs.

Optimize: Resource allocation to ensure funding aligns with needs and maximizes impact.

Identify: Service gaps and unmet needs to ensure equitable access to care for all children.

Inform: Data-driven policy decisions to build a stronger, more responsive, and equitable behavioral health system for Connecticut's children.

Conclusion

This study will provide the data and insights needed for direct effective resource allocation, timely intervention, and ultimately, improving outcomes for Connecticut's children's behavioral health crisis response system.

CONTINUUM OF CRISIS SERVICES STUDY RECOMMENDATION

Connecticut is experiencing a significant increase in children's behavioral health needs.

The Mobile Crisis Intervention Services Annual Report revealed in 2024:

11,346 episodes of care were delivered by mobile crisis intervention services.

8,428 children received services

While mobile crisis services have advanced, limited community-based support results in overuse of emergency departments, which are not ideally suited for children's developmental needs in crisis.

Expanding community-based crisis intervention is essential to de-escalate situations and ensure children receive appropriate care.

Crisis Service Continuum Study Scope

Evaluate the use of 211/988, mobile crisis services, UCCs, sub-acute stabilization, and EDs to improve behavioral health crisis response.

Evaluate outreach strategies and referral pathways to improve accessibility and coordination.

Analyze current service utilization, marketing efforts, outreach strategies, referral pathways, and resource allocation.

Identify service gaps to ensure equitable care.

The Impact of UCCs in 2024:

95.7% of children served returned home or to their communities.

49.1% of families would have otherwise relied on the ED.

This study will provide data and insights to inform effective resource allocation, timely intervention, and ultimately, improved outcomes for Connecticut's children's behavioral health crisis response system.

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School Based Health Center Study Recommendation

Background

School Based Health Centers (SBHC) are imperative to children's behavioral health, as they have been shown to improve health outcomes, education outcomes, and the utilization of services. SBHC's have been reported to be the ideal location for youth-focused services, given that they are in locations that allow both primary care and mental health staff to collaboratively address student's health needs. SBHCs face a variety of barriers, including insufficient staffing, provider burnout, competing salary and benefits (which negatively impact recruitment and retention), high caseloads, inequities in insurance reimbursement, and documentation requirements. In Connecticut, the Department of Public Health funds 91 SBHC sites in 27 communities.

What are School Based Health Centers?

- SBHCs are licensed as outpatient clinics or as hospital satellites, as stated by the *Connecticut Department of Public Health,* and are staffed with Advanced Nurse Practitioners, Physician Assistants, or Pediatric/Family Medical doctors who can assess, diagnose, treat, and make external referrals to specialists, according to the *Connecticut Association of School Based Health Centers*
- School Health Services staff and School Based Health Center Practitioners work together to:
  - Coordinate care for the student
  - Create a culture of health within the school community to include students, families, school staff, and private practitioners
  - Adress social determinants of health and identify barriers students may face

Data

SBHCs can help with academic success.

- According to the *Los Angeles Trust for Children's Health*, student attendance increased by 5.4 school days per year following a visit to SBHC.
- Students' attendance increased by 7 school days per year after attending a SBHC visit for a mental health diagnosis.

SBHCs are available to populations that may face barriers of care.

- According to the Findings from the *2022 National Census of School Based Health Centers, about* 80% schools served by SBHCs were Title 1 schools, and around 70% students in schools with access to an SBHCs were youth who were Black, Indigenous, and POC
- According to the report the *Evaluation of the Impact of School Based Health Centers*, SBHC's can increase access to services and help improve outcomes by reducing or removing many of the barriers experienced by the students, families, and communities they serve

TCB Recommendations

Recommendation 1: It is recommended that TCB contract with an outside entity to conduct a School Based Health Center (SBHC) study for:

a. Developing and administering a survey to better understand current data collection practice and the anticipated challenges and opportunities in implementing a more robust data and QI system.
b. Identifying effective reporting standards for SBHC's to report to the Department of Public Health (DPH).
c. The study will be designed and piloted in collaboration with the Department of Public Health (DPH) and the department of Children and Families (DCF).
d. A standardized definition of SBHCs.

Recommendation 2: It is recommended that all School Based Health Centers (SBHCs) report to DPH the following effective January 1st, 2026, annually thereafter

a. Establish comprehensive reporting across all SBHCs to inform targeted investment by utilizing reporting mechanisms outlined in the study above.

Conclusion

The enaction of the TCB School Based Health Center Study recommendations will allow for SBHCs to implement standardized methodologies for evaluating data, outcomes, and service costs, as well as identify barriers to services.

SCHOOL BASED HEALTH CENTER RECOMMENDATION

School-based health centers (SBHCs) are crucial for children's behavioral health, improving health and educational outcomes while increasing service utilization. Their location within schools makes them ideal for collaborative primary care and mental health services addressing student needs.

The Impact & Challenges of School-Based Health Centers (SBHCs)

SBHCs are licensed as outpatient clinics or hospital satellites staffed by medical professionals who provide comprehensive care, from assessment to treatment to referrals. SBCH's staff collaborate with school personnel to coordinate student care, foster a healthy school environment and address social determinants of health.

3,900 SBHCs across 49 states and Washington D.C. (2022)

91 SBHC sites funded by the Department of Public Health across 27 CT communities.

Students receiving school-based mental health services have lower suspension rates & better peer relationships.

Barriers Facing SBHCs

- Staffing shortages
- Provider burnout
- High caseloads
- Salary competition
- Documentation burdens
- Insurance reimbursement inequities

Inequities persist in both healthcare access and provider representation, with racial minorities underrepresented in mental health professions.

The enaction of the TCB School Based Health Center Study recommendations will allow for SBHCs to implement standardized methodologies for evaluating data, outcomes, and service costs, as well as identify barriers to services.

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Workforce Stabilization Recommendations

Background

Across the United States, behavioral health staff have been experiencing burnout, yet the need for behavioral health services continues to be in high demand. There is an ongoing need for both clinical and non-clinical behavioral health workers to meet the needs of individuals seeking services. Addressing barriers to the workforce is imperative to improving both access to behavioral health services and supporting the needs of both the staff and the individual seeking services.

Facts

- **93% of behavioral health workers have reported burnout across the United States, according to the National Council for Mental Wellbeing.**
    - Such contributing factors include the inability to offer competitive salaries and benefits, a lack of qualified applicants, and staff burnout.

- **According to the 2024 Behavioral Health Insurance Coverage and Payment Parity in HUSKY, Private Insurance, and Medicare Advancement Report, as of 2022, there were substantially more providers per 100,000 enrollees in commercial insurance compared to HUSKY for all provider types, with psychologists having the largest difference.**
    - Specifically, there was four times the number of psychologists seeing patients enrolled in commercial insurance than in HUSKY.
    - ***This same report found that 1.54 million people in Connecticut live within mental health workforce shortage areas.***

- **The Intensive In Home Child and Adolescent Psychiatric Services (IICAPS) is utilized in Connecticut, with the children and families who use IICAPS having often shown histories of significant and chronic developmental stress, adversity, and trauma.**
    - IICAPS disproportionately serves families of minority racial and ethnic groups compared to the state and primarily serves youth eligible for Medicaid.
    - With the utilization of IICAPS, the completion rate is high for complex populations (75%).

- **The Alliance Voice of Community Nonprofits 2022 report found that 91% of the surveyed non-profit organizations reported experiencing difficulties in recruiting employees being faced with an average vacancy rate of 18%.**

- This report also found that 59% of nonprofits currently have a waiting list for community services, 68% of nonprofits say that demand for services has increased in the past two years, and 94% of nonprofits say that additional funding would allow them to fill more open positions.

TCB Recommendations

1. **It is recommended that the Department of Social Services conduct a feasibility determination and fiscal analysis to estimate adding a billing code to help off-set initial costs for on-boarding and training clinical staff in evidence-based models, before they can bill for services (e.g. "observation and direction"). This should include:**
   a. Potential Medicaid reimbursement for training and ramp-up, where extensive clinical training in an evidence-based model is needed before billing can occur.
   b. Feasibility assessment and fiscal analysis estimate should be submitted no later than October 1st, 2025.

2. **The Department of Social Services should include as part of the Certified Community Behavioral Health Clinics (CCBHCs) planning and designing grant the following:**
   a. the development of separately payable acuity-based care coordination service to improve outcomes of children,
   b. a value-based payment model that holds providers accountable and rewards them for improved outcomes,
   c. and navigation support.

3. **It is recommended that the Department of Social Services and Intensive In Home Child and Adolescent Psychiatric Services (IICAPS) Model Development and Operations (MDO) at the Yale Child Study Center, review and design levels of the IICAPS model for consideration. This should be reported back to the TCB by October 1st, 2025.**
   a. Such model should consider the needs and time-demands placed on families and children, and the ability to deliver positive outcomes in a sustainable manner.

4. **It is recommended that TCB contract with IICAPS Model Development and Operations (MDO) at the Yale Child Study Center to**

a. determine what additional federal funding and reimbursements may be available to IICAPS MDO and the IICAPS network as an evidence-based/promising practice treatment program, and if determined prudent,

b. conduct a randomized controlled trial (RCT) of IICAPS for purpose of qualifying IICAPS federally as an evidence-based treatment program. Interim recommendations to TCB by October 1st, 2025.

Conclusion

The enaction of the TCB Workforce Stabilization recommendations will result in the reduction of barriers to workforce retention and recruitment and costs for behavioral health services due to the potential reimbursement of the initial onboarding and training of clinical staff costs based on evidence-based models. The recommendations will allow for the enhancement of care coordination and navigation support to individuals seeking services through Certified Community Behavioral Health Clinics (CCBHCs). The review and design of IICAPS levels will ensure that staff can deliver sustainable positive outcomes. As IICAPS has led to a 47.1% reduction in emergency department visits for individuals utilizing those services, it is imperative for the securement of sufficient funding.

WORKFORCE STABILIZATION RECOMMENDATION

The demand for behavioral health services in Connecticut is outpacing Medicaid funding, contributing to service gaps and disparities.

Nonprofits Struggling to Meet Demand

The National Council for Mental Wellbeing reports that 93% of U.S. behavioral health workers experience burnout.

91 % of non-profits struggle to recruit employees.

18 % average vacancy rate

Driven by factors such as:

- Inability to offer competitive salaries and benefits.
- Lack of qualified applicants
- Staff burnout

This workforce shortage is reflected in access to care.

Increasing the Service Gap

59% have waiting lists for community services.

94% say more funding would help fill open positions.

According to the *2024 Behavioral Health Insurance Coverage and Payment Parity in HUSKY, Private Insurance, and Medicare Advancement Report* :

4x more psychologists per 100K enrollees in commercial insurance vs. HUSKY.

1.54 million CT residents live in mental health workforce shortage areas.

The TCB Workforce Stabilization recommendation focuses on improving workforce retention, reducing behavioral health service costs, and enhancing care coordination through evidence-based models.

For IICAPS, redesigning service levels will ensure sustainable outcomes, **as evidenced by a 75% success rate and a 47.1% reduction in emergency department visits, underscoring the need for adequate funding.**

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