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April 9th, 2024

2:00-3:30PM

Zoom

TCB Services Workgroup Agenda

1. **Introductions**
2. **Legislative Updates**
3. **Workplan Review and Discussion**
    a. Review Draft Workgroup Workplan
    b. Feedback and Discussion
4. **UConn Services Array Updates**
5. **Next Steps**

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TCB Services Workgroup April Meeting Summary

April 9, 2025
2:00 p.m. – 3:30 p.m.

Attendance

Atneciv Rodriguez	Jason Lang	Michael Patota	
David McSergi	Jennifer Nadeau	Mickey Kramer	
Edith Boyle	Jill Farrell	Naomi Libby	
Erika Sharillo	Joanne Tremblay Jackson	Rita Demo	
Erin Williamson	Karen Snyder	Stephanie Bozak	
Ingrid Gillispie	Katerina Vlahos	Yann Poncin	
Jack Lu	Kristen Parsons		

TYJI Staff

Erika Nowakowski
Emily Bombach
Jacqueline Marks

Meeting Objectives:

- Legislative Updates
- Workplan Review and Discussion
- UConn Services Array Updates
- Next Steps

Meeting Summary:

1. ***Legislative Updates:***
   a. TCB has three bills going through the legislative process.

      i. HB 6951 had a public hearing on February 20, 2025, through the children's committee, and on March 12, 2025, it was sent to the appropriations committee. HB 6951 includes a recommendation for a crisis continuum study, a school-based health center study, and the sustaining funding for mobile crisis recommendation. Please see link to the bill here: 2025HB-06951-R00-HB.PDF
      ii. HB 7109 was referred out of the Children's Committee into the Human Services Committee, and a public hearing was held on March 6, 2025. HB 7109 includes recommendations regarding amending the age for insurance coverage for ABA-applied behavioral health analysis therapy for individuals with autism spectrum disorders, a review of private insurance billing for Urgent Crisis Centers (UCCs), the IICAPS recommendations, and the design of the CCBHC planning grant. Please see link to the bill here 2025HB-07109-R00-HB.PDF
      iii. HB 7263 had a public hearing on April 3, 2025, and was referred to the Joint Committee on Appropriations. HB 7623 would allow for the Behavioral Heath Advocate and two providers of substance abuse disorder who treat youth to be appointed to the TCB committee. Please see link to the bill here 2019HB-07263-R00-HB.PDF

2. ***Workplan Review and Discussion***
    a. The workgroup co-chairs reviewed the purpose statement, priorities and workgroup goals.
    b. The workgroup members provided feedback to extend workgroup membership.
        i. The workgroup members suggested extending workgroup membership to out to The Department of Mental Health and Addiction Services (DMHAS) and Young Adult Services (YAS) to include young expecting parents. They also suggest including the Trafficking in Persons Council (TIP) and Transitional Support Services (TSS), because it provides specialized services for Transitional youth between the ages 18 - 21.

3. ***UConn Services Array Updates***
    a. The workgroup members were encouraged to join the Service Array Survey subgroup.
    b. The survey will be sent to stakeholders for targeted feedback, the subgroup will review the feedback received, then the survey will be piloted with approximately five providers for qualitative feedback over the next two weeks. The survey is set to be distributed to the public at the beginning of May.
    c. The type of services intended to be understood though the survey is prevention, early intervention, crisis services, screening and assessment, mental health treatment, substance use treatment, recovery services, care coordination, care management, peer support, Intellectual and Developmental Disabilities (IDD), and other supports. The providers range from clinics, The CT Association of School Based Health Centers, and other specific stakeholders to ensure data collection is not redundant.

4. ***Operational Updates***
    a. The regular meeting dates have changed for the next two months due to an overlap with TCB committee so the next two workgroup meetings will occur on May 7th and June 4th. The workgroup meeting will return to regular dates starting in July.
    b. The 2025-2028 Strategic Plan will be voted on at the April TCB Meeting.
    c. The Community Voice Workgroup will be introduced at the April TCB monthly meeting.

5. ***Next Meeting:***
    a. May 7th, 2025 2:00 p.m. – 3:30 p.m.

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TCB 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. **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.
11. **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.
12. **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
13. **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).
14. **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).
15. **Co-morbidity:** Having more than one disorder or illness at the same time.
16. **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.
17. **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.")
18. **Evidence-Based Practice:** The use of current best evidence in making decisions about the care of individuals. This approach must balance the best evidence with the desires of the individual and the clinical expertise of health care providers. Evidence Based Treatment is any practice that has been established as effective through scientific research according to a set of explicit criteria (Drake et al., 2001). These are interventions that, when consistently applied, consistently produce improved client outcomes. Some states,

government agencies, and payers have endorsed certain specific evidence-based treatments such as cognitive behavioral therapy for anxiety disorders and community assertive treatment for individuals with severe mental illness and thus expect that practitioners are prepared to provide these services.

19. **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.
20. **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.
21. Fiscal Year (FY): The state's budget year which runs from July 1 to June 30.
22. **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's or legal guardian's consent or knowledge.
23. **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.
24. **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.)
25. **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.
26. **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.
27. **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.

28. **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.
29. **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.
30. **Mental Illness:** A state of emotional and psychological unrest characterized by alterations in thinking, mood, and/or behavior, causing distress and/or impaired functioning.
31. **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.
32. **Outpatient:** A patient who receives medical and/or mental health treatment without being admitted to a hospital.
33. **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 actually read aloud.
34. **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.
35. **Statute:** Another name for a law. "The statutes" are the General Statutes of Connecticut.
36. **Supplemental Security Income (SSI):** A disability program of the Social Security Administration.
37. **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-theart 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

DRAFT 2025 ANNUAL SERVICES WORKGROUP WORKPLAN:

Workgroup Co-Chairs: Edith Boyle, LCSW & Yann Poncin, MD

Suggested Services Purpose Statement: Ensure 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.

**In first workgroup meeting the membership will discuss adding "…to expectant parents and children from birth to age 22…"*

Priorities: The identified priorities include peer-to-peer support and 211 services. The workgroup will monitor the TCB recommendations related to the crisis continuum, UCC's and IICAPs. Additionally, the group will prioritize and track legislation regarding access to care for children and young adults covered by private/commercial insurance.

Short-Term Workgroup Goals:

- Identify meeting schedule, frequency of meetings, and meeting presentations with the workgroup
- Identify and finalize workgroup priorities with feedback from the workgroup
- Review of 2025 TCB legislation with the workgroup, refine how this workgroup will monitor and track the passed legislation
    - For TCB recommendations that do not pass in legislation, the workgroup will identify how they would like to proceed on those specific recommendations.

Medium-Term Workgroup Goals (2025):

- Consistent monitoring of TCB 2025 passed legislation and updates on the status of the implementation progress will be given at each services workgroup meeting.
- Collaborate with identified responsible state agencies and private organizations on progress of implementation, barriers, and needed adjustments.
- Services Array Survey (Implementation, distribution, collection, and analysis)
    - Identify a distribution date and distribution list
    - Ensure a periodic review of the response rate, if there is a low response rate, the workgroup will identify other strategies for dissemination to increase the response rate
- Review services array survey results
    - Review the draft report accompanying the results

    - Review draft report with TCB leadership
- CT Peer-to-peer support and services
    - Assess peer-to-peer support and services in the state through presentations, workgroup expertise, literature reviews, and completed studies.
- Monitor 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, subacute crisis stabilization centers, and hospital emergency departments for such services, outreach and marketing strategies common sources of patient referrals to such service providers, the allocation of state and other financial resources to such service providers, and the anticipated demand for behavioral health services for children into the future.
    - Identify who we will be partnered with to complete the study.
    - TYJI to release RFQ for research partner on the study
    - Once awarded, work with the researcher on the implementation of the study
    - Monitor progress of study, review findings and data analysis
    - From the data, assess best practices for Crisis Continuum staffing, evaluate models used and identify best practices from across the State,
    - From the data, assess scan of hours of services used that operate 24/7
- Monitor the IICAPS study (multiple factors)
    - The study will review and design levels of the IICAPS model for consideration. Such a model should consider the needs and time demands placed on families and children and the ability to deliver positive outcomes sustainably.
    - What additional federal funding and reimbursement may be available to IICAPS MDO and the IICAPS network as an evidence-based/promising practice treatment program, if determined prudent to do so.
    - Randomized controlled trial (RCT) of IICAPS to qualify IICAPS federally as an evidence-based treatment program. Recommendation to TCB by Oct. 2025
- Monitor the UCC Report:
    - The report will include a review of private health insurance coverage for treatment of children at urgent crisis centers and be reported to the TCB no later than October 1st, 2025.
    - Identify barriers and gaps in services
- Operationalize how the workgroup integrate work with the Prevention and School-Based Workgroups (e.g., UConn Services Array Results, 2025 and 2026 recommendations)
- Assess and monitor additional non-TCB 2025 legislation regarding access to services for children and young adults covered by private/commercial insurance
    - Identify barriers to care and gaps in services
- Develop a set of 2026 draft recommendations with the workgroup and present recommendations to the TCB committee in fall of 2025*

- TCB leadership will review drafts and provide feedback
- Draft Workgroup recommendations will be presented at the October TCB Meeting

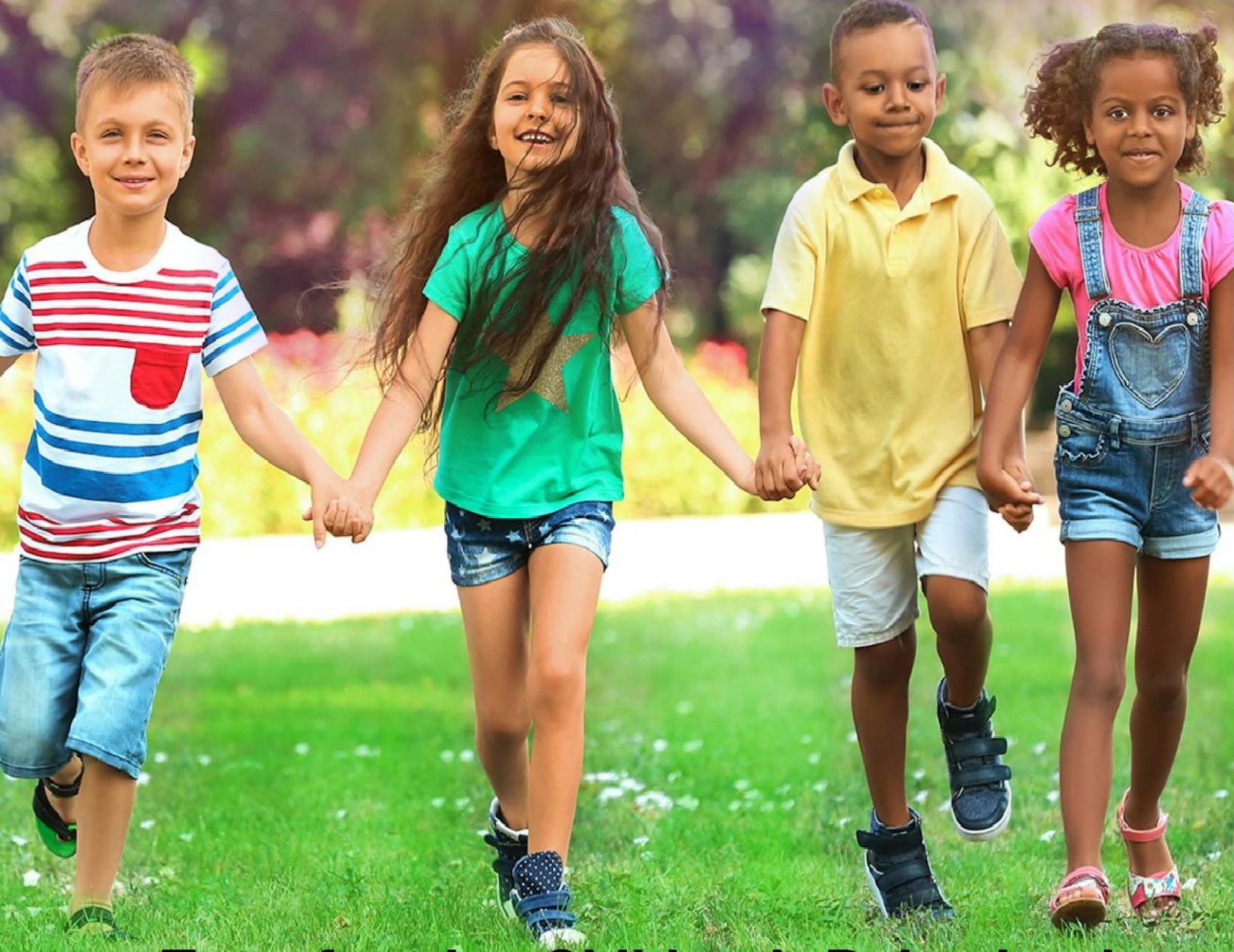
** The development of 2026 recommendations is dependent on priorities, and progress within the group. If the group does come up with a set of recommendations, the decision to proceed with 2026 legislative recommendations package depends on committee and leadership feedback*

Long-Term Workgroup Goals (2025-2028):

*Other priority areas and strategies identified in the strategic plan will be added to the workplan annually

- Utilize information from the workgroup to plan for 2026, 2027, and in subsequent years.

Meeting Schedule: Services Workgroups are set to Start April 9th, 2025, and recur on the second Wednesday of the month from 2-3:30 PM. All meetings will be virtual. Meeting agendas and the Zoom link will be sent out before the meeting each month.



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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Workgroup Operational and Engagement Rules

1. Membership & Roles

Workgroup Composition

- Members will include representatives from key stakeholders such as legislators, state agencies, school administrators, educators, mental health professionals, parents, students, and advocacy organizations.
- Participation is voluntary, but active engagement is expected.
- Additional members may be invited based on expertise and workgroup needs.

Roles & Responsibilities

- **Chair/Co-Chairs:** Lead meetings, set agendas, facilitate discussions, and ensure accountability.
- **Members:** Provide expertise, review policy proposals, participate in discussions, and contribute to assigned tasks.
- **TYJI Staff:** Handle scheduling, documentation, and logistical support.

2. Meeting Structure & Procedures

Frequency & Scheduling

- Meetings will be held at least once a month, with additional sessions scheduled as needed.
    - School-Based Workgroups are set to begin **April 7th, 2025**, and reoccur on the **first Monday of the month** from **3:00-4:30 PM**. All meetings will be virtual. Meeting agendas and the Zoom link will be sent out before the meeting, each month.
- Meetings may take place in person or virtually to accommodate accessibility.

Agenda & Documentation

- Agendas will be shared prior to each meeting to allow for preparation.
- Meeting minutes will be documented and distributed within one week following each meeting.
- Action items and follow-ups will be tracked to ensure accountability.

3. Decision-Making Process

Consensus-Based Approach

- The workgroup will prioritize consensus in policy recommendations and decisions.
- If consensus cannot be reached, differing viewpoints will be documented.

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4. Confidentiality

- As participants, we will respect the confidentiality of all discussions and information shared durin g the meeting. We will not disclose any sensitive or personal information outside of the meeting without explicit consent.

5. Respectful communication

- We will treat each other with respect and courtesy. We will use inclusive language and avoid any f orm of discrimination, bullying, or harassment. We will express disagreements constructively and respectfully.

6. Accountability

- We will take personal responsibility for our actions and commitments. We will follow through on agreed-upon tasks and deadlines. Should any of us be unable to fulfill a commitment, we will communicate openly and promptly to find a solution or reassign the task.

7. Meeting Conduct & Logistics

- Mute microphones when not speaking (for virtual meetings) and use chat features professionally.
- Follow the meeting agenda while allowing flexibility for emergent topics as needed.
- Submit agenda items in advance when possible to ensure efficient discussions.