Human Services Committee
JOINT FAVORABLE REPORT

Bill No.: HB-7109
Title: AN ACT CONCERNING MEDICAID COVERAGE FOR APPLIED BEHAVIOR ANALYSIS SERVICES, IMPLEMENTING CERTAIN RECOMMENDATIONS OF THE TRANSFORMING CHILDREN'S BEHAVIORAL HEALTH POLICY AND PLANNING COMMITTEE AND ABUSE INVESTIGATIONS INVOLVING BEHAVIORAL ANALYSTS.
Vote Date: 3/19/2025
Vote Action: Joint Favorable Substitute
PH Date: 3/6/2025
File No.: 471

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SPONSORS OF BILL:

Human Services Committee

CO-SPONSORS OF BILL:

Rep. Jane M. Garibay, 60th Dist.
Rep. Tammy R. Exum, 19th Dist.

REASONS FOR BILL:

Connecticut children are experiencing a mental health crisis as sharp increases in suicidality, severe anxiety, major depression, and self-harm are occurring among those with or without an autism diagnosis. This crisis is readily apparent in the massive increase in emergency department (ED) visits – 13,064 visits by children covered by HUSKY in 2023 alone. Inadequate and dramatically underfunded home and community-based services are often unavailable, resulting in as many as 200 children at any given time being "stuck" in EDs for days, weeks, or even months without care, services or supports, and with no place to go to receive even basic services. Waitlists are long, even for those known to be eligible for care and coordination of care falls far short of the need. "Federal Medicaid law entitles covered children to timely evaluation and connection to medically necessary services and failure to meet these federal requirements violates children's rights to care" (Center for Children's Advocacy). The state's "Transforming Children's Behavioral Health Policy and Planning Committee (TCB)" has made several recommendations resulting in this proposed legislation.

SUBSTITUTE LANGUAGE:

In Section 1(b), "need" was inserted before "not be limited" for clarity; in Section 1(b)(2), "services" was inserted after "analysis" for consistency; in Section 2(c), provisions relating to topics covered in the report were redrafted for clarity; in Section 3(c) "established pursuant to section 2- 137 of the general statutes" was added after "Committee" for consistency; in Section 8(b)(1), "46-120" was changed to "46b-120" for accuracy; in Section 10, "analyses" was changed throughout to "analysis" for consistency; and in Section 10(c)(1), "or their designees" was inserted for accuracy.

RESPONSE FROM ADMINISTRATION/AGENCY:

Connecticut Department of Social Services (DSS), Commissioner, Andrea Barton Reeves*:* stated that applied behavioral analysis (ABA) is already covered as part of autism services, and in 2024 DSS leveraged $7 million in state funds to provide rate increases in BH codes, with priority given to a code on the ASD fee schedule, and Section 1(a)(2) of this bill requires extended coverage of ABA services under HUSKY B (CHIP), but adding this coverage would cost approximately $3.7 M ($1.3 M state share). The increases are not accounted for the in the Governor's recommended budget. Section 1(a)(3) would require reimbursement for training using ABA, although current reimbursement can already incorporate some extent of caregiver training during the direct delivery of services to a child. If this is meant to extend services beyond that already covered, there is no funding for such increases. Section 1(b) requires DSS to submit a report that explains progress in expanding care and the Department believes this is unnecessary. Section 2 requires the OEC and DSS to make recommendations for regulatory and reimbursement framework for the deliver of ABA, and Section 3 requires DSS to consult with MHAS and DCF to include in the CCBHC planning grant support for development of reimbursement for acuity-based care coordination and a value-based payment model to help with navigation of BH resources. Section 4 requires the Commissioner to consult with Yale Child Study Center to review intensive in-home child and adolescent services and other evidence-based models to deliver BH issues in sustainable manner. It was stated DSS looks forward to working collaboratively on all recommendations in Section 2.

The Commission on Women, Children, Seniors, Equity & Opportunity (CWCSEO), Policy Analyst, Duborg, Christian: supports the bills effort to address the increasing prevalence of MH disorders among children and adolescents through increasing Medicaid reimbursements rates for supervision, assessment, and direct services by BCBA under the HUSCKY B health program. The recent OHS study showed reimbursement rates in HUSKY were lower than establishment benchmark rates across all BH and medical service. If not addressed this inequity can result in significant long-term costs to the state and lifelong ramifications for the individual.

Office of the Child Advocate, Acting Child Advocate, Christina D. Ghio, JD, CWLS: supports the requirement to address Medicaid rates as one piece of the puzzle of accessibility and agrees that a rate setting structure is essential to ensuring prompt access to Medicaid services. OCA supports the recommendation to review the legislative and regulatory framework, background checks, and oversight structure. OCA issued a report in February, "Review of State Oversight of Entities Providing ABA Treatment to Children" and

found that, unlike other types of services to children, the substantial gaps were identified in facility licenses, inspections, vetting of employees including criminal background checks or checks of DCF Central Registry. No state agency regulates staff ratios, sanitation, or food service as is customary in relation to childcare centers. Further, no mechanism in law is in place that allows DCF to notify DPH or OEC of a neglect/abuse allegation or substantiation, or to notify an ABA service provider if an employee is substantiated for child abuse or neglect. While discipline findings regarding licensed BACB staff are on e-license, this does not extend to non-BCBA staff, and although licensed BABC and PTs are mandated reporters, other staff employed by the entity are not. OCA recommended a task force make recommendations regarding a statutory and regulatory framework and that statutes be immediately amended to allow/require: 1) DCF to notify DPH of the results of investigations involving a licensed BCBA, modeled after those related to notifications of allegations involving school employees, 2) that all individuals working under the supervision of a licensed behavior analyst working with children be mandated reporters; and 3) that all ABA service providers be required to provide patients, or their parents/legal guardians, information on how to report concerns to DCF. OCA has been meeting with OEC, DPH, DCF and a representative of Autism Services, and would ask for the opportunity to submit proposed revised language for Section 2, and review of possible intervention prior to children reaching the point where they are at risk for hospitalization or leaving an ED, including flexibility to reduce intensity and increase intensity to meet the needs of the child and family. The Urgent Crisis Centers (UCCs) provide families with an alternative to the ED when their children are in crisis. In 2024, an average of 91% of youth at three community UCCs were connected to care and only 4% were sent to the ED and the cost is 650% less than the cost of the ED, however, a sustainability plan is needed for UCCs. OCA supports the requirement to extend coverage to age 26.

Office of Early Childhood (OEC), Commissioner, Beth Bye: supports Section 2 of the bill that requires OEC, along with DSS and in consultation with the Autism Spectrum Disorder Advisory Council (ASDAC), to make recommendations regarding the need for comprehensive background checks and the need for an oversight structure that can assure the safety and quality of services to a highly vulnerable population. OEC looks forward to the opportunity to collaborate, but respectfully requests an extension of the timeframe to December 1, rather than September 1, 2025.

NATURE AND SOURCES OF SUPPORT:

Tow Youth Justice Institute, The Administrator to the Transforming Children's Behavioral Health Policy Planning Committee (TCB), Senior Project Manager, Emily Bohmbach, MPH: strongly supports this bill that is a direct response to recommendation of the TCB, a committee with membership from State Agencies, legislators, community members, and advocates who share the goal of improving children's BH outcomes. This work highlights the need for reimbursement of acuity-based care coordination through CCBHC grant planning, and without the staff, resources, and support, behavioral health services will not be utilized to their optimal advancement. The bill requires consultation with the Yale Child Study Center to review In-Home Child and Adolescent Psychiatric Services (IICAPS) and other evidence-based alternatives that focus on delivering positive outcomes for children who utilize behavioral health services and to provide recommendations regarding IICAP models if it qualifies federally as an evidence-based treatment program. Support was stated for

amending the age of coverage for ASD treatments from 21 to 26, the age at which individuals can remain on their parents' insurance policy and would increase access to care and prevent a disruption in services. It is stated, the TCR supports requiring review of private health insurance coverage for children who utilize urgent crisis centers (UCCs) as it is imperative for the state to have data on the utilization of these services to identify access needs and gaps in service.

Center for Children's Advocacy, Executive Director, Sarah Healy Eagan, JD: supports the bill which will help address gaps in MH services and bolster the state's effort to improve families' access to needed care. Suicidality, severe anxiety, major depression, self-harm has contributed to a massive increase in emergency department (ED) encounters, and individuals sometimes are "stuck" in the ED for days, weeks, or even months without even basic care that is needed. CCA strongly supports enhancing reimbursement rates for autism services, extending coverage for ABA services to those served by HUSKY B, ensuring that state agencies address gaps in access to and oversight of community-based autism clinics. Further, they believe it is important to require an examination of IICAPS utilization and applications for access to intensive in-home services for families. It is time to move beyond the long waitlists and service deserts where little or no in-home service exists (450 families are currently on the waitlist for IICAPS). As federal Medicaid law entitles covered children to timely evaluation and connection to medically necessary services and failure to meet these federal requirements violates children's rights to care, CCA would remove language regarding "within available appropriations," in the bill as they pertain to services required to meet the needs of Medicaid-eligible children.

Connecticut Hospital Association, Anonymous: CHA urges the state to take immediate action to augment the availability of BH services, both in the hospital and in the community. The COVID-19 pandemic exposed and aggravated deficiencies in Connecticut's behavioral health system. Rising numbers of people of all ages are experiencing mental health and substance use issues due to isolation, fear, and delays in care are compounded by chronic staffing shortages. The crisis is evident in hospital emergency departments (EDs), which are often the only option for people who cannot access care in more appropriate settings. Consideration must be given to establishing Medicaid reimbursement for acuity-based care coordination services to improve behavioral outcomes, review intensive in-home child and adolescent psychiatric services (IICAPS), and report on the status of private health insurance coverage for the treatment of children at behavioral health urgent crisis centers (UCC). CHA supports these efforts to inform improvements to the behavioral healthcare system, such as establishing Medicaid rate structures for initiatives like children's behavioral health UCCs, making emergency mobile psychiatric services available statewide during high-demand times, expanding community-based and school-based services to all areas of the state, and instituting Medicaid reimbursement for other care coordination initiatives, including but not limited to collaborative care model (COCM) services and community care teams (CCTs).

Cultivate Behavior Health and Education, Board Certified Behavior Analyst & Clinical Manager, April Almeida: strongly supports the proposed changes in Section 1. As a provider of ABA services, the barriers that Medicaid families face when trying to access crucial supports is apparent. It is stated, the 3.5% rate increase in Phase 1 was insufficient, as Connecticut's reimbursement rates remain significantly lower than those of neighboring states. This disparity hinders the availability of qualified providers and limits access for families who rely on Medicaid-funded services. The recent lowering of the income threshold

for Husky A has forced many families out of coverage, leaving them without essential ABA services. Unlike commercial insurance, Medicaid does not currently reimburse for caregiver training, even though it is a required and vital component of effective ABA treatment. Establishing a Medicaid reimbursement code for this service will improve outcomes for children by equipping parents with the skills needed to support their progress. Aligning Medicaid's billing codes with those used by commercial insurance carriers will simplify administration, reduce confusion, and enhance the efficiency of service delivery. These measures are essential to ensuring equitable access to ABA services for children with autism in Connecticut. Without appropriate reimbursement and policy alignment, Medicaid families will continue to struggle with service availability, delays in care, and provider shortages.

Yale Child Study Center (YCSC), Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS), Assistant Clinical Professor of Social Work and Clinical Director, Victoria Stob, LCSW: supports the expansion of intensive services for children at risk for psychiatric in-patient hospitalization and 6 months of IICAPS costs approximately the same as a 12-day hospitalization. IICAPS is a complex model that requires extensive clinical support, ongoing training, and quality assurance analysis. Decades of data have shown that families who receive IICAPS and complete 6 months, have fewer inpatient psychiatric admissions, fewer ED visits, fewer residential stays, improved functioning, and decreased symptom severity. Last year, IICAPS Medicaid rates were increased after a decade of neglect and one-time supplemental grant funding from the (DCF) prevented the collapse of the IICAPS network. The total number of families served has gone from roughly 900 in FY 22/23 to roughly 1300 in FY 23/24. However, there is still more work to do, with IICAPS at one point averaging 2000 families successfully discharging annually. This level of care is worth investing in as studies have repeatedly demonstrated expanding access to BH care to the most vulnerable and high-risk is a financially viable cost-reduction strategy in the long term. The Program is requesting additional funds for the onboarding and training arm (IICAPS MDO) to support agencies in onboarding and/or bringing on new staff.

Effective School Solutions (ESS), CEO, Duncan Young: supports the focus on evidence-based youth BH programs and the proposed partnership with YCSC, as ESS also partners with them. ESS urges the committee to consider other proposals ESS presented to the TCB committee, such as, piloting a school-based high acuity MH program to launch at the beginning of the 2025-2026 academic year, and to examine outcomes in conjunction with a research-based university, evaluating the impact on absenteeism, academic performance, disciplinary events, psychiatric hospitalization, utilization of intensive outpatient services, and weeks spent in a higher level of care. Early outcomes could be presented in the TCB January 2026 legislative report. Further, it was stated the Committee should create financial incentive programming to encourage districts to build in-district therapeutic programs to reduce outplacements and offer districts one-time grant funding to build therapeutic programs that have a specific goal of reducing outplacements.

Smith, Elizabeth, MS, BCBA, LBA, Owner and Director of C.O.R.E., Bethel, CT. and Past President of CTABA. The codes used by Medicaid in Connecticut are a mix and match of HCPCS (CMS) codes and CPT (AMA) codes. The CPT codes for ABA became permanent in 2018 - there are a total of ten CPT codes used specifically for adaptive behavior assessment and treatment services. Connecticut Medicaid adopted two of these codes (97153 and 97158) but continued using HCPCS codes for the remainder of ASD services. Most other

state programs have converted fully to the CPT Codes (includes appended information in testimony).

Testimony in support was given by the following individuals holding a credential of BCBA-D/BCBA and LBA (or others); some are officers/members of Connecticut Association for Behavior Analysis (CTABA): and support one or more of the following provisions: 1) Increasing Medicaid rates of payment for supervision, assessment, and direct service of Behavior analysts. Reimbursements in CT remain low when compared to neighboring states. 2) Providing Funding for Husky B & increasing the age cap. When a family exceeds the Husky A threshold they lose all funding. The threshold was lowered this year which is pushing more families over the limit. 3) Providing Medicaid reimbursement for Caregiver Training. Medicaid, unlike all commercial policies, does not currently have a code for this service, although evidence supports its efficacy. 4) Standardizing Medicaid Codes so they align with codes used by commercial insurance companies. This is the practice of neighboring states and will support a better understanding of the services provided under each billing code.

Gregory, Lisa, CEO, Milestones Behavioral Services: supports.

Palazzo, Judith, BCBA, LBA, VP of Behavioral Services, Milestones Behavioral Services: supports.

Wehmann-Bell, Britta, BCBA LBA, Clinical Director, Milestones Behavioral Services
Cranmer, Liz, MS, LBA, BCBA, Milestones Behavioral Services: supports.

Chiu, Jerome T., Insurance Resource Center for Autism and Behavioral Health, Owner, RadBX (ABA management consulting), and Member CTABA: member of the team that implemented ABA coverage for MassHealth in 2014 and managed the ABA benefit for MBHP as the ABA codes shifted from Experimental (H-codes), to Temporary (T-Codes), to the S1 (9-Codes).

Faressa, Christine, Founder & President, Sun, Moon, Stars, Inc.: parent.

Gallaway, Dr. David, Psy. D, BCBA-D, Senior VP of Operations, Beacon Services of CT: parent.

Gordon, Catherine, BCBA, LBA, Clinical Director, Children's Behavioral Services, Benhaven, New Haven, CT, & Public Policy and Legislative Chair for CTABA: providing in-home, community, and center-based ABA, but does not accept HUSKY recipients b/c of low reimbursement.

Hansen, Kara, MA, BCBA, LBA, Clinical Director, IRIS Behavioral Health Services, LLC., Waterbury, Meriden, and New Britain areas, and Member CTABA.

Hartman, Carrie, MS, BCBA, LBA, Director of Clinical Services, Area Cooperative Educational Services, Hamden, CT, and Member CTABA.

Jensen, Jaime L., MA, BCBA, LBA, Clinical Coordinator, Children's Health Services, Benhaven, New Haven, CT.: I have personally experienced providing the devastating news

to families when their insurance switched from Husky A to Husky B, resulting in complete loss of autism service coverage and an abrupt stop in vital services.

Kaye, Arlene Dworkin, MS, CCC-SLP, BCBA, LBA, Clinical Coordinator, Children's Health Services, Benhaven, New Haven, CT. and Public Policy and Legislative Chair for CTABA.

Lavole, Amy, MS, BCBA, LBA, Owner, Synct Collaborative Therapy, and President, CTABA.

MacKay, Robert, Senior ABA Therapist, Creative Interventions, LLC, Windsor, CT., and Member CTABA.

McKenna, Pamela, Director of Clinic-Based Services, Creative Interventions, LLC., and Member, CTABA.

Miller, Jimnahs, and Razumnaya, Yana, CoChairs, Autism Spectrum Disorders Advisory Council (ASDAC).

Parenteau, Joanna, Med, BCBA, LBA, Clinical Director, Synct Collaborative Therapy, and Board of Directors CTABA.

Powers, Seth D., MBA, MPH, Co-Executive Director, The Center for Children with Special Needs, Glastonbury, CT & Farmington, CT.

Saunders, Dr. Melissa, EdD, BCBA-D, LBA, LABA, Chief Operating Officer, Creative Interventions. Also lists: Scott Levine, CEO; Justine Randall, MS. Ed, BCBA, LBA, LABA Executive Director of Behavioral Services, and Maris Pelkey, MA, BCBA Executive Director of Birth to Three Services.

Schemer, Evan, Owner, The SEED Center, Stamford, CT and Public Policy and Legislative Committee for CTABA.

Ventura, Santimer, Behavior Blocks, Clinical Director.

Wong, Jessica, MA, BCBA, LBA, Autism Behavioral Health, Executive Director, and Member, CTABA.

Testimony submitted by parents, family and friends in support of the bill:

Mearman, Kimberly A., Ph.D.: parent of adult daughter; specifically supports removal of age limits on coverage.
Randall, Mike: foster parent.
Redwood, Steve: parent.
Smith, Elizabeth: parent.
Taylor, Helen M., Founder/President, The Social Chase, Inc., and parent.
White, David: grandparent.

GENERAL COMMENTS WITH RECOMMENDATIONS

Connecticut Community Nonprofit Alliance (TheAlliance), Public Policy and Advocacy Associate, Monika Nugent: urges this committee to remove Section 3 from the bill. Section 3 requires that the CCBHC planning grant include several provisions such as reimbursement for specific services into the grant and a value-based payment model for children's services. While the intent of this section is understood, these proposed requirements would already be part of the CCBHC model. The CCBHC model is a continuum of care across the lifespan, however, this bill is legislating a program that has yet to be established. Concern is stated with the prospect of forcing DSS to implement a value-based payment structure that penalizes providers who do not meet certain benchmarks. There is no need to mandate such a program in the law. We believe that the steering committee and planning needs to take place first before any requirements be put into statute.

NATURE AND SOURCES OF OPPOSITION:

Private Plans Instead, Lechner, Lindsey: opposes expansion of services within Medicaid, and proposes subsidies for transitioning to a system where low-income individuals can access private insurance, reduce administrative inefficiencies but also drive down costs through competition, improving both service quality and patient outcomes. In 2022, Medicaid accounted for over 30% of state budgets, with federal spending set to grow at an unsustainable rate of 5.5% annually. According to a 2019 study in Health Affairs, Medicaid recipients report worse access to care, longer wait times, and lower satisfaction levels compared to those with private insurance. Private insurance allows individuals more personalized, flexible coverage, and the competitive market fosters innovation that Medicaid lacks.

Reported by: Rebecca McClanahan **Date: April 10, 2025**