CONNECTICUT
Policy and Management

The Office of Policy and Management

Health and Human Services Policy and Planning Division

REPORT TO THE JOINT STANDING COMMITTEES OF THE GENERAL ASSEMBLY

On Human Services and Public Health

Pursuant to Public Act 25-89, Section 5

February 1, 2026

I. Background

In accordance with section 5 of PA 25-89, the Secretary of the Office of Policy and Management created a working group in consultation with the Governor's Kids Cabinet. This working group was charged with examining the feasibility of developing an interagency complex case team for young adults ages 17 to 22 with intellectual or developmental disabilities (ID/D), including autism spectrum disorder (ASD), who have co-occurring behavioral health needs, are in urgent need of community placement or agency services, and may qualify for support from more than one state agency. The report is required to include the following information: (1) findings on the necessity of creating a formalized process to address long hospital stays for such young adults and safe discharges with community supports; (2) summary of best practices identified in other states; (3) recommendations concerning state appropriations necessary to operationalize any recommended process; (4) recommendations regarding a referral process for complex case team management; and (5) proposed legislation to implement any recommended process.

II. Summary of Findings

The Office of Policy and Management (OPM) conducted the initial research to identify best practices in other states and gather relevant data on the need for establishing a complex case team in Connecticut. Three working group meetings were held with state agency commissioners and subject matter experts to review state models and discuss potential recommendations. OPM also met with stakeholder groups to hear accounts of the impact of long hospital stays and systemic challenges for this specific cohort of individuals who are engaged with multiple state agencies.

Summary of State Models

The work group reviewed four state models, including how each state developed a system of care or process for addressing the complex needs of young adults with ID/D and ASD who also require behavioral health services and treatment in their state systems.

Pennsylvania formed a working group which created a blueprint that outlined recommendations to improve access to treatment, supports and services for children under 21 years old who have complex needs. The development of the blueprint resulted in 18 total recommendations across six themes which seek to (1) prioritize prevention and strengthen system response, (2) improve information sharing and resource navigation, (3) provide state guidance and support county multi-system planning efforts, (4) identify administrative efficiencies and support the systems, (5) understand system capacity and direct service solutions, and (6) strengthen trauma comprehension and application. Pennsylvania then created three staff positions in the Secretary's office: two clinical directors who provide direct technical assistance to counties and a special assistant to oversee the clinical directors and the implementation of the blueprint recommendations, including ongoing policy planning and interagency collaboration.

Ohio took a multi-year systematic approach to create a specialized managed care model that provides behavioral health services to all Ohio residents aged 0-20 years old who have complex care needs. The OhioRISE program is a coordinated system of care that provides community-based support and services. Ohio reports that this initiative has reduced the number of emergency department visits and psychiatric hospital stays, the length of hospital stays, and out-of-state placements. Prior to the implementation of OhioRISE the state utilized an interagency review team. They accepted referrals when counties were struggling to find appropriate community-based in-state support and services to meet the youth's

needs. This interagency team was provided with a multi-million-dollar budget that allocated temporary funding to counties for individualized supports and services or funded additional testing while permanent solutions were identified.

New Jersey also developed a system of care for children aged 0-21 through an administrative services organization (ASO) model under their Department of Children and Families. The contracted system administrator is a single point of access to their array of services that include behavioral health, substance use, and intellectual and developmental disability services for youth and families statewide. The concept for an integrated system of care was developed through a SAMHSA grant and further assessed by a stakeholder taskforce.

Massachusetts developed an interagency review team for complex cases through legislation. The team reviews cases in which an individual is waiting in a hospital emergency department, medical bed, at home or other location and is in urgent need of placement. The team is comprised of state agency representatives and is provided with funding to assist with additional testing and/or temporary solutions for placement. They maintain a website with eligibility information and referral forms.

Summary of Discussion on State Models

Many states have committed to a large-scale multi-year approach to improve the overall delivery of children's behavioral health services in their state. The working group agreed to focus recommendations and discussions on the narrower scope indicated in the legislation. Broader system-level reforms were identified as important areas for future consideration but were beyond the scope of this report. In addition, the group recognized that Connecticut has multiple working groups and councils who are already focused on improving the behavioral health system. For example, the Transforming Children's Behavioral Health Policy and Planning Committee (TCB) developed their strategic plan for 2025-2028 and identified 12 overlapping children's behavioral health advisory bodies.

The model currently used in Massachusetts was the most feasible model for the working group to consider. The agencies identified an existing process already in use to review cases across the Department of Mental Health and Addiction Services (DMHAS), the Department of Developmental Services (DDS) and the Department of Children and Families (DCF). This clinical interagency team meets quarterly; however, the current review structure lacks a formalized process as compared to the Massachusetts model.

It is also of note that Pennsylvania established staff positions to provide technical assistance and engage in policy planning. While Connecticut already has two staff positions at OPM who engage in interagency collaboration and policy planning for ASD and ID/D, these positions do not provide clinical support to agencies through technical assistance.

All the states reviewed have updated their children's behavioral health system to serve young adults over 18 years old, and most are now providing services until age 21. In Connecticut, PA 23-137 amended in part, subsection (b) of §10-76d of the Connecticut General Statutes, to require that special education services be continued, for those with an Individualized Education Program (IEP), through the end of the school year in which an individual turns 22 years old. The Connecticut behavioral health system currently transitions kids at 18 years old from the DCF Voluntary Care Management Program (VCM) to the DMHAS Young Adult Services (YAS) program. The DMHAS YAS program provides behavioral health

services through age 25. These services are for eligible school-aged individuals who need to continue their mental health treatment while transitioning to adult services. DMHAS has resources to ensure the continuation of special education in collaboration with the school district and multiple levels of care to meet individual treatment needs. Connecticut has a children's behavioral health system comprised of community providers; not all services are delivered by DCF. Carelon coordinates access to care for children receiving Medicaid. They have been contracted by DCF to facilitate the connection to needed behavioral health services for youth under 18 years old in VCM who cannot access these services through other means. There is not a clear continuation of residential behavioral health treatment services for students with ID/D between 18 years old and 22 years old. DDS plans for transition after the completion of high school to provide eligible youth with waivered services. DDS waivers offer a range of services within appropriated funds each year. Employment/day programs are typically made available to all individuals upon graduation from the school system. Residential services at DDS are more limited; resources are available to fund emergencies and certain target initiatives, such as individuals with older caregivers or specific types of programs such as supportive housing. It is important to note that DDS is the lead agency for individuals with ID/D and has the ability pursuant to CGS §17a-227 to license and regulate residential facilities for people with an intellectual disability, including children. However, they do not provide behavioral health services in their home and community-based waiver programs, nor can they license behavioral health treatment facilities. All behavioral health services for DDS individuals are accessed through adult Medicaid providers in community settings or hospitals. Currently, DDS operates a children's services program that provides eligible families respite and positive behavior support services, and, if children with ID/D require behavioral health assessments or treatment, families can access these services in the community through private insurance or Carelon.

III. Recommendations

1. Formalize a higher-level review process for complex cases in Connecticut.

The state agencies (DDS, DCF, DMHAS and SDE) can use the current meeting structure and formalize a process through an interagency Memorandum of Understanding (MOU). The MOU must clarify the following: (1) meeting frequency, (2) members, (3) referral criteria, (4) referral process, including who can elevate a request for review, (5) timeline for review and determination, (6) plan submission and follow-up, and (7) a process for dispute resolution. The team will communicate their final de-identified plans to OPM to ensure implementation.

This process can be accomplished quickly, within current agency appropriations and staffing. The review team will collect data, determine if future appropriations are required, make recommendations on how the funding will be used, and identify policy suggestions or statute changes required for operational purposes. The state system is currently supporting this cohort and therefore agencies can use current processes for budget requests to support case level needs. OPM will help facilitate the development of the higher-level review process and ongoing state agency collaboration.

2. Close gaps in the behavioral health system for young adults with ID/D who are receiving VCM services through DCF but are not eligible for transition to the DMHAS YAS program.

There is a need to provide system flexibility for the delivery of behavioral health services for those school-aged individuals with an ID/D diagnosis in the DCF VCM program who do not qualify for transition to the DMHAS YAS program at 18 years old.

This service gap became apparent when special education statute CGS §10-76d was amended in section 32 of PA 23-137 to now require boards of education to provide special education programs and services to school-aged children until the child has graduated from high-school or until the end of the school year during which such child reaches age 22, whichever occurs first. However, this did not change the State Department of Education's definition of "child" under CGS §10-76a, which is still defined as any person under 21 years of age. Therefore, education services are still being provided despite the unchanged definition of "child" but not all children's services are aligned with these changes.

In response to the change in special education services, DCF updated licensing statute in PA 25-116 to permit a licensed "childcare facility" to continue providing residential services under CGS §17a-145 to individuals who are eligible to receive special education services through the school year in which they turn 22 years old. Therefore, a licensed childcare facility can continue to serve individuals over 18 years old who are entitled to special education. CGS §17a-14 clarifies this transition for those who are in custody of the DCF Commissioner, stating those in residential treatment facilities for behavior problems with special education programs can remain in place beyond eighteen years of age until their program is completed. The payment of board and care costs are paid by DCF provided the individual meets eligibility requirements. However, school aged individuals who are receiving services through the VCM program are not in custody of DCF.

Some steps have been taken in Connecticut to improve transition from children's services to adult services, however DDS and DCF lack some of the transition structures that have been created at DMHAS. The higher-level review process in recommendation #1 will allow the state agencies to continue to work through these system structure challenges and can shape future policy changes. Temporary solutions are needed to improve discharge options for these school-aged individuals to ensure they can finish their education in an appropriate setting with the least amount of disruption while work toward long-term system solutions continues.

DCF and DDS will continue to collaborate in transition planning for these school aged individuals with complex needs, who require the continuation of residential behavioral health treatment services with the least amount of disruption. Providers will be permitted to continue to serve an individual after they turn 18 years old consistent with CGS §17a-145. If DDS was resourced for an individual via the age out planning process, then they will be responsible for board and care costs. DDS will continue planning for transition to their HCBS waivers for all eligible individuals with ID/D who are receiving residential treatment services through VCM at the end of the school year in which they turn 22 years old. If a school-aged individual under this definition displaces from DCF VCM services or is in urgent need of placement the agencies can collaborate through an MOU and the higher-level review process outlined in recommendation #1 to solve unique service needs that may arise. DMHAS will continue to transition eligible VCM individuals without an ID/D diagnosis to the YAS program, including those who have a qualifying behavioral health treatment need and who may also have an autism diagnosis or other developmental disability, who do not qualify for services under a DDS waiver. DDS will continue to utilize community behavioral health resources for all individuals in their care as appropriate.

OPM will convene state agency cross collaboration meetings and work alongside the Transforming Children's Behavioral Health Committee to identify long term solutions to behavioral health transition for school aged youth with complex needs.

3. Build additional infrastructure to address behavioral health system gaps for young adults (14-21) with ID/D who require residential treatment.

It was clear during the workgroup conversations that there is a lack of specialized treatment options for this population. The agencies are successfully transitioning the majority of people, but they hit roadblocks when a service doesn't exist in the system, or all current treatment options are full or do not meet the individual's needs. The DCF and DDS shared case list of individuals with ID/D and a behavioral health diagnosis has fluctuated over time, the current range is from 12 to 25 individuals. However, this population is growing and there is a clear need for additional levels of care. OPM proposes that a 10-bed Psychiatric Residential Treatment Facility (PRTF) be developed to serve children and youth aged 14 to 21, through a Request for Proposals (RFP) under the Department of Social Services (DSS) in collaboration with DCF, DDS and DMHAS. An assessment will be undertaken to determine whether current agency appropriations can support the RFP, and ongoing treatment services for the PRTF which will be billable under Medicaid. If the assessment determines that an RFP can be developed, it is strongly recommended that agencies assess (1) if any current state-owned properties could be utilized for the PRTF, (2) if there is a way to solve for those who turn 22 years old while receiving treatment, and therefore cannot have their services billed to Medicaid children's services, (3) the percentage of beds that will be held specifically for those with an ID/D diagnosis, and (4) if a PRTF is the best treatment option to meet the needs for this population.

Creating a short-term residential treatment option will create needed infrastructure in Connecticut to assist with discharge from acute settings to a lower level of care and may prevent inappropriate acute placements for medication management and behavioral health treatments for school aged individuals with ID/D.

IV. Conclusion

In conclusion, there is a need to formalize a higher-level review process between agencies, as they are often presented with unique scenarios that may not have a clear single agency solution. Formalizing the current process through a joint agency MOU will allow the agencies flexibility and ensure a response is communicated and implemented. In addition, there is a need to address system capacity to support the unique needs of this population. System improvement starts with shared agency values and collaboration in order to find solutions that will improve the system experience for youth with complex needs and their families. Defining agencies' statutory responsibilities with greater clarity would assist in addressing identified system gaps and supporting enhanced infrastructure, both in developing a specialized treatment option and building expertise through cross-agency collaboration, adding to system capacity. Connecticut is committed to addressing system gaps and finding solutions to meet the behavioral health needs of all children and young adults. OPM wishes to thank everyone who participated in the development of these recommendations.