REVIEW OF KEY LEGISLATION RELATING TO PROVIDERS OF SERVICES TO THE ELDERLY

2022

REGULAR SESSION OF THE CONNECTICUT GENERAL ASSEMBLY

PREPARED BY:

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TABLE OF ACRONYMS

APRN	Advanced Practice Registered Nurse
CON	Certificate of Need
DCP	Department of Consumer Protection
DOH	Department of Housing
DOI	Department of Insurance
DOL	Department of Labor
DMHAS	Department of Mental Health and Addiction Services
DPH	Department of Public Health
DSS	Department of Social Services
FY	Fiscal Year
HIPAA	Health Insurance Portability and Accountability Act of 1996
IRC	Internal Revenue Code of 1986, as amended
LTCO	Long-Term Care Ombudsman
OHS	Office of Health Strategy
OPM	Office of Policy Management
PA	Physician Assistant
RCH	Residential Care Home
RN	Registered Nurse

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I. BUDGET / IMPLEMENTER

1. PUBLIC ACT 22-118. AN ACT ADJUSTING THE STATE BUDGET FOR THE BIENNIUM ENDING JUNE 30, 2023, CONCERNING PROVISIONS RELATED TO REVENUE, SCHOOL CONSTRUCTION AND OTHER ITEMS TO IMPLEMENT THE STATE BUDGET AND AUTHORIZING AND ADJUSTING BONDS OF THE STATE.
   Effective as noted

   §§ 69-70 – Collaborative Drug Therapy
   Effective July 1, 2022

   These Sections make various changes to statutes affecting collaborative drug therapy management agreements. A collaborative drug therapy management agreement is an agreement between one or more qualified pharmacists and one or more prescribing practitioners to manage the drug therapy of, and devices prescribed to, individual patients, or a patient population, based on a written protocol or a collaborative drug therapy care plan. "Qualified pharmacist" is defined to mean a pharmacist who: (a) is deemed competent under DCP regulations; and (b) has reviewed the latest edition of the "Pharmacists' Patient Care Process" published by the Joint Commission of Pharmacy Practitioners.

   Section 69 imposes a limit on the authorizations afforded to qualified pharmacists through a collaborative drug therapy management agreement or collaborative drug therapy management policy to specifically prohibit them from establishing a port to administer parenteral drugs (e.g., IV infusions).

   Each written protocol or collaborative drug therapy care plan created must contain detailed direction of the actions that qualified pharmacists may perform for the patient or patient population. Examples of the type of information that may be included follows:

   - The specific drug or drugs, therapeutic class of drug or classes of drugs or the devices to be managed by the qualified pharmacists;
   - The terms and conditions under which drug therapy may be initiated, modified, continued, discontinued or deprescribed, or use of a device may be initiated, continued or discontinued, or a device may be deprescribed;
   - The conditions and events upon which qualified pharmacists are required to notify the prescribing practitioner;
   - The laboratory tests that may be ordered; and
   - A definition of the patient population included in such written protocol or collaborative drug therapy care plan.

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Qualified pharmacists are required to notify the prescribing practitioner of any instance in which drug therapy is discontinued or deprescribed no later twenty-four (24) hours after such decision is made.

All activities performed by the qualified pharmacists in addition to the protocol or collaborative drug therapy care plan used must be documented in the patient's medical record in accordance with the prescribing practitioner's policies, or in the case of a care-giving institution, which would include a licensed nursing home, all applicable care-giving institution policies. And, each collaborative drug therapy management agreement, collaborative drug therapy management policy, written protocol and collaborative drug therapy care plan must be made available for inspection by DPH and DCP.

Section 70 simply augments the authority of a medical director of a nursing home facility to establish protocols for a prescription drug formulary system in accordance with guidelines established by the American Society of Health-System Pharmacists and any applicable collaborative drug therapy management agreement to now also include the ability to do so in accordance with the guidelines of a collaborative drug therapy management policy.

§ 79 – Health Care Provider Loan Reimbursement Program
Effective May 7, 2022

This Section requires the Office of Higher Education to establish a health care provider loan reimbursement program by January 1, 2023. The health care provider loan reimbursement program must provide loan reimbursement grants to health care providers licensed by DPH who are employed full-time as a health care provider in this State.

Eligibility requirements for the loan reimbursement grants shall be established by the Executive Director of the Office of Higher Education, in consultation with DPH, and may include, but need not be limited to, income guidelines. The Executive Director must consider health care workforce shortage areas when developing such eligibility requirements. Furthermore, at least 20% of the loan reimbursement grants must be awarded to graduates of a regional community-technical college.

Persons who qualify for a loan reimbursement grant must maintain full-time employment as a health care provider in this State and will be reimbursed on an annual basis for qualifying student loan payments in amounts determined by the Executive Director of the Office of Higher Education.

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The Office of Higher Education is permitted to accept gifts, grants and donations, from any source, public or private, for the health care provider loan reimbursement program.

§ 136 – Emergency Medical Services Working Group
Effective July 1, 2022

This Section requires the Commissioner of DPH, in collaboration with the Commissioner of DSS, to establish a working group on emergency medical services. The working group must convene its first meeting by September 1, 2022, and must include, although it need not be limited to, the commissioners or their designees, representatives of volunteer emergency medical services providers, representatives of municipal or other nonprofit agencies that provide emergency medical services, representatives of hospital-based emergency medical services providers and representatives of for-profit emergency medical services providers. The working group may also include representatives of hospitals, emergency physicians, representatives of long-term care providers, representatives of health carriers and other emergency care providers.

The working group must examine the following issues: (i) Medicaid and private commercial emergency medical services rates; (ii) the emergency medical services workforce; and (iii) the provision of emergency medical services, including, but not limited to, the adoption of mobile-integrated health care, and the provision of emergency medical services in other states.

The Commissioner of DPH, in consultation with the Commissioner of DSS, must submit a report to the Joint Committee of Public Health with recommendations concerning the working group's findings and recommendations for improvements to the provision of emergency medical services in the State and actions to take to create an effective and sustainable emergency medical services system over a long-term period.

§§ 143-144 – Connecticut Premium Pay Program
Effective May 7, 2022

This Section establishes the Connecticut Premium Pay program for eligible applicants who worked during the entire period of the public health and civil preparedness emergency declared by the Governor on March 10, 2020, up to May 7, 2022. Applicants must have been categorized into phase 1a or 1b of the COVID-19 vaccination program to be eligible. Note that eligible applicants do not include federal, state or municipal workers or those who did or could have worked from home. Eligible applicants are also subject to the following income restrictions:

- Full-time (i.e., worked thirty (30) hours or more per week) eligible applicants:

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INCOME RANGE	ELIGIBLE PAYMENT
< $100,000	$1,000
$100,000 - $109,999	$800
$110,000 - $119,999	$600
$120,000 - $129,999	$400
$130,000 - $149,999	$200
> $150,000	$0

- Part-time (i.e., worked less than thirty (30) hours per week) eligible applicants:

INCOME RANGE	ELIGIBLE PAYMENT
None	$500

The Comptroller's Office will oversee administration of the program or contract with a third-party to serve as administrator. The administrator is authorized to accept and review applications, summon and examine witnesses under oath who may provide information pertinent to establishing eligibility, direct the production of records and examine such records to establish eligibility and take affidavits or depositions within or outside of the State.

This Section also establishes the Connecticut premium pay account to operate as a separate, non-lapsing account within the General Fund. Moneys in the account are to be used to pay compensation for approved claims as well as fund the administration of the program. Administrative costs are capped at 5% of the total funds received by the Connecticut premium pay account.

All claims must be submitted to the program administrator (i.e., the Comptroller's Office or some designated third-party administrator) by October 1, 2022, and such claims must include proof of eligible employment and any additional information required by the administrator. No payments will be made under the program after June 30, 2024.

The administrator is to provide determinations to each applicant no later than sixty (60) business days after submission of a claim or within ten (10) business days after any requested additional information has been received. Applicants may request that their eligibility be reconsidered by filling out the designated form within twenty (20) business days of the initial determination being mailed. The administrator will then assign the appeal to a third-party within three (3) business days after receipt of the request. The third-party is required to make their final determination on the claim within twenty (20) business days after the individual's request for reconsideration was received.

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Any statement, document, information or matter may be considered to determine an applicant's eligibility under the program. There is no right to an appeal the decision made based upon a request for reconsideration.

The administrator can seek repayment of any benefits paid erroneously or those paid to parties under false pretenses or willful misrepresentation. The administrator is authorized to seek a penalty of up to 50% of the value of the benefits received. Additionally, anyone who intentionally aids an applicant in wrongfully obtaining funds is subject to the same penalty imposed on the applicant.

The Comptroller must submit a report to the administrator indicating the value of the Connecticut premium pay account by July 31, 2022, and monthly thereafter.

The administrator is also required to report to the Joint Committee on Labor by September 1, 2022, and quarterly thereafter. The report must include the account's value, the estimated value after scheduled payments, an estimate of the monthly administrative costs and any recommendations for legislation to improve the program.

Section 144 prohibits employers from discharging, discriminating against or misinforming or misleading any employee who files an application for premium pay pursuant to Section 143. Any employee who is discharged, disciplined or discriminated against may bring a civil action in the superior court in the jurisdiction in which their employer is located. Employees are eligible to seek back wages, reinstatement of benefits and punitive damages. Lastly, any employee that prevails in such an action will be awarded reasonable attorney's fees and costs.

§ 193 – PCA Workforce Council and Labor Union MOU
Effective May 7, 2022

Section 193 officially approves the memorandum of agreement between the Personal Care Attendant Workforce Council and the New England Health Care Employees Union, District 1199, SEIU, including any attachments or appendices, and any provisions that require supersedence of a law or regulation.

§ 194 – Paid Family Leave Anti-Retaliation
Effective July 1, 2022

This Section extends existing protections against employer retaliation for workers who exercise their rights under the State's Family and Medical Leave Act to also cover workers exercising their rights to paid family medical leave. In accordance with existing rights under the Family and Medical Leave Act, workers who are now aggrieved by a violation of the Paid Family and Medical

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Leave Act may also file a complaint with the Commissioner of Labor within 180-days of the alleged action that prompted the complaint (unless good cause exists for a late filing). Such workers are also granted a private right of action in civil court which they may exercise without first filing an administrative complaint, again, on par and in accordance with their rights under existing law for employer violations of the Family and Medical Leave Act.

§ 205 – Expansion of the Essential Workers COVID-19 Assistance Fund
Effective May 7, 2022

The 2021 budget act (Public Act 21-2) created the Connecticut Essential Workers COVID-19 Assistance Program and the "Connecticut Essential Workers COVID-19 Assistance Fund" to offer assistance to affected persons (i.e., an essential employee who died or was unable to work due to a laboratory confirmed case or an officially diagnosed case of COVID-19 between March 10, 2020 and July 20, 2021) on a first-come, first-served basis until June 30, 2024 (for our full summary of section 289 of Public Act 21-2, see pp. 3-4 of the 2021 LeadingAge Legislative Summary (*link here*).

The program remains largely unchanged; however, this Section makes the following noteworthy updates:

- Extends the deadline to apply for assistance from July 20, 2022, to December 31, 2022;
- Adds persons employed in a category recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices to receive a COVID-19 vaccination in phase 1c of the COVID-19 vaccination program to the definition of "essential employee";
- Removes the qualification that "uncompensated leave" does not include any leave from employment for which the affected person received paid leave provided through a paid leave plan provided by the employer or pursuant to state or federal law;
- Adds amounts paid through a paid leave plan provided by an employer or pursuant to state or federal law to the list of deductions that will be made when calculating the amount of aid to be provided to the affected person;
- In circumstances where the administrator determines that more information is needed to determine the total amount of aid for the affected person, authorizes the administrator to pay the affected person for the completed parts of their claim while the remainder of the claim is pending;
- Establishes that the administrator shall not deny a claim because a claimant has already filed a disability or unemployment claim, so long as the benefits provided under the program are offset by any disability or unemployment benefits already paid to the claimant for their uncompensated leave, including payments made without prejudice;

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- Clarifies that affected persons who have received unemployment benefits are not required to be currently employed with such previous employer to qualify for assistance under the program; and
- Authorizes the administrator to review any previously denied, or currently pending, claim for assistance under the program and make a new determination of eligibility.

§§ 217-222 – Health Care Cost Growth and Quality Benchmarks
Effective May 7, 2022

These Sections establish a process for setting and publicizing annual health care cost growth and quality benchmarks for the State. While they do not directly affect, or impose obligations on, providers of services to the elderly, it is worthwhile to understand how the process will work, as development of these health care benchmarks has been a significant initiative for the Lamont administration and OHS.

Section 217 directs OHS to establish annual health care cost growth benchmarks, health care quality benchmarks and primary-care spending targets as a percentage of total medical expenses. Section 217 also directs OHS to develop strategies in consultation with stakeholders to meet these benchmarks and targets. In addition, OHS must enhance transparency of "provider entities" (which are defined in Section 218 as an organized group of clinicians that come together for contracting, or are an established billing unit, and have enough covered lives to participate in "total cost of care contracts"). OHS must also monitor the development of accountable care organizations and alternative payment methodologies in the State.

Section 219 directs the Executive Director of OHS, every five (5) years, to develop, adopt and post on their website new annual benchmarks for the subsequent five (5) years. By July 1, 2022, OHS was supposed to publish on its website the health care cost growth and primary care spending targets as a percentage of total medical expenses for calendar years 2021 to 2025 and the annual health care quality benchmarks for the calendar years 2022 to 2025.

In developing the health care cost growth benchmarks and primary care spending targets, OHS must consider historical and forecasted changes in median income in the State and the growth rate of potential gross state product, the inflation rate and OHS's most recent report on performance against benchmarks and targets (see Section 220 discussion below). The OHS Executive Director must hold at least one informational public hearing before adopting the health care cost growth and primary care spending targets for each five-year period. If the average annual health care cost growth for a new five-year set of annual benchmarks increases by more than 0.5% over the previous benchmarks, the new benchmarks must be submitted to the General Assembly's Committee on Insurance for review and approval.

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In developing the health care quality benchmarks, the Executive Director of OHS must consider certain specified information such as new quality measures developed by nationally recognized health organizations for health quality benchmarks and measures that concern health outcomes, patient safety overutilization and underutilization, patient centeredness as well as community health or population health concerns. The OHS Executive Director must hold at least one informational public hearing before adopting health care quality benchmarks for each five-year period.

Section 220 directs that each year, health care payers (e.g., insurers) and/or provider entities must submit specified cost and quality data necessary for the Executive Director to determine whether the benchmarks are being met. The Executive Director must use this data, along with data collected from the federal Centers for Medicare & Medicaid Services, to publish annual reports concerning each health care benchmark on the OHS website.

Section 221 directs the Executive Director of OHS to use the health care payer and provider data to identify any payer or provider entity that falls short on any health care benchmark. Prior to identifying any payer or provider entity as deficient, the Executive Director must first meet with them upon request to review and validate the expense data provided and amend the OHS findings, if necessary. Payers or provider entities found deficient shall be sent a notice by the Executive Director explaining the factual basis for the identification.

Section 222 directs the Executive Director of OHS to hold annual informational public hearings to discuss both the health care quality benchmarks and health care cost benchmarks. The informational public hearing on the growth of total health care expenditures compared to the health care cost growth benchmark must be convened by June 30, 2023, and annually thereafter. The informational public hearing to compare the performance of payers and provider entities to the quality benchmarks for such year shall be held no later than June 30, 2024. The Executive Director may require any payer or provider entity to participate in the health care cost growth hearings if the payer or provider has been found to be a significant contributor to health care cost growth or has failed to meet the primary care spending target and may also require hearing participation of any other entity (such as a drug manufacturer) that has been found to be a significant contributor to health care cost growth. Similarly, any payer or provider entity that has failed to meet health care quality benchmarks may be required to participate in the health care quality benchmark hearing. Those required to participate must provide information on actions taken to improve future performance.

Finally, Section 222 directs the Executive Director of OHS to prepare and submit reports to the Joint Committees on Insurance and Public Health by October 15, 2023, and October 15, 2024, respectively, and annually thereafter, summarizing findings from each of the respective health care

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quality and health care cost annual public hearings. The reports are to be published on the OHS website, along with any recommendations from the OHS Executive Director concerning strategies or new legislation to improve the State's health care system.

§ 234 – Connecticut Homecare Program for Elders Co-Payment Reduction
Effective July 1, 2022

This Section modifies the Connecticut Homecare Program for Elders, administered by DSS, to lower the co-payment amount which individuals who qualify for assistance under the program must pay from 4.5% to 3% of the cost of their care. The reduction applies to individuals whose income is less than 200% of the federal poverty level as well as to those individuals whose income exceeds 200% of the federal poverty level.

§ 235 – Increase to Community Spouse Protected Amount
Effective July 1, 2022

This Section requires the Commissioner of DSS to amend the Medicaid state plan to set the minimum community spouse resource allowance at $50,000 and authorizes the Commissioner to adopt regulations necessary to implement this Section. This Section requires the Commissioner of DSS to issue a report on the impact of increasing the minimum community spouse resource allowance to the Joint Committees on Aging, Human Services and Appropriations by July 1, 2023. The report must contain, but shall not be limited to, the following:

- The number of community spouses able to keep additional assets because of the increase in the minimum community spouse resource allowance; and
- The cost to the State of increasing the minimum community spouse resource allowance.

§ 242 – Changes to DSS American Rescue Plan Allocation for Temporary Financial Relief to Nursing Homes Based on Difference Between Issued and Calculated Rate
May 7, 2022

In the State's 2021 budget (through Public Act 21-2, Section 321), $10 million was allocated to DSS under the American Rescue Plan to provide temporary financial relief in the form of grant allocations issued on a one-time basis to nursing homes based upon the percent difference between the facility's issued and calculated rate, subject to pro rata adjustment based on available funding. This Section eliminates the requirement for DSS to adhere to the aforementioned allocation restrictions when making these grants to nursing homes out of the remaining funding.

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§ 243 – Community Ombudsman Program
Effective July 1, 2022

Note, see summary of Public Act 22-146, section 2, which was enacted after the 2022 Budget Act was passed and appears to have superseded this Section by requiring that the LTCO's appointment of a Community Ombudsman be done within available appropriations. Unlike Public Act 22-146, section 2, this Section of the 2022 Budget Act permitted the LTCO to hire both a Community Ombudsman supervisor and not more than twelve (12) regional community ombudsmen. Section 2 of Public Act 22-46 only authorizes the appointment of the Community Ombudsman.

§§ 244-245 – Ban of No-Hire Clauses in Contracts with Homemaker-Companion Agencies and Home Health Agencies
Effective May 7, 2022

Current law provides that employment contracts concerning the provision of companion, or home health services shall not include covenants not to compete and officially declares such provisions as being against public policy, void and unenforceable. Sections 244 and 245 provides additional protections for employees of homemaker-companion agencies and home health agencies by explicitly prohibiting no-hire clauses from being used in contracts between a homemaker-companion agency or a home health agency and their clients and further provides that no-hire clauses in such contracts are also considered void and against public policy.

For both Sections, a "no-hire clause" means a provision of a contract between the homemaker-companion agency or home health agency, as applicable, and a client of such agency that (a) imposes a financial penalty, (b) assesses any charges or fees, including legal fees or (c) contains any language that can create grounds for an assertion of breach of contract or a claim for damages or injunctive relief against the client for directly hiring an employee of such agency.

§ 359 – Bonds to Develop Housing for Health Care Workers
Effective July 1, 2022

This Section provides that the State Bond Commission shall have the power from time to time to authorize issuance of State bonds in one or more series and in principal amounts not exceeding, in the aggregate, $20 million. The bonds issued under this Section will have a maturity date no longer than twenty (20) years from their date of issuance. The proceeds from the sale of the bonds are earmarked for use by DOH to (i) develop housing for health care workers, including, but not limited to, land acquisition, project design and costs of construction, in collaboration with the Chief

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Workforce Officer and (ii) curtail costs associated with the work of the Commissioner of Housing and the Executive Director of the Connecticut Housing Finance Authority in seeking a partnership with one or more hospitals located in this State to increase workforce housing options.

No bonds will be authorized until a request, signed by the Secretary of OPM, has been filed with the State Bond Commission. The State Bond Commission may, in its discretion, require that such request include certain terms and conditions. Note that bonds issued under this Section will be deemed general obligations of the State and, thereby, the full faith and credit of the State will be pledged for the full payment of principal and interest when due. Appropriation of all amounts necessary for the punctual payment of such principal and interest will be made and paid by the State Treasurer.

Lastly, the Commissioner of Housing and the Executive Director of the Connecticut Housing Finance Authority must seek a partnership with one or more hospitals to increase health care workforce options and, by January 1, 2023, submit a report detailing the status of the partnership and any recommendations on other methods to increase such housing options to the General Assembly's joint standing committee having cognizance on housing matters.

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II. ACTS AFFECTING NURSING HOMES AND ASSISTED LIVING

2. PUBLIC ACT 22-145. AN ACT CONCERNING ELDER ABUSE REPORTING DEADLINES, TEMPORARY FAMILY ASSISTANCE, CERTIFICATES OF NEED FOR LONG-TERM CARE FACILITIES AND CIVIL PENALTIES FOR NURSING HOMES THAT FAIL TO USE RATE INCREASES FOR EMPLOYEE WAGE ENHANCEMENTS.
Effective July 1, 2022, except as otherwise noted

§ 1 – Shortened Reporting Deadline for Reporting Suspected Elder Abuse to Elderly Protective Services

This Section shortens the timeframe whereby mandatory reporters must report or cause a report to be made, when they have reasonable cause to suspect or believe that elder abuse, neglect, exploitation or abandonment has occurred, from seventy-two (72) hours to no later than twenty-four (24) hours after such suspicion or belief arose.

This Section also modifies existing law to require mandatory reporters who fail to report for the first time to retake and provide the Commissioner of DSS with proof of their successful completion of, the mandatory training on detecting potential elder abuse. Mandatory reporters who subsequently fail to report elder abuse within twenty-four (24) hours will then be fined up to $500 and must, again, retake and provide proof of successful completion of the mandatory training on detecting elder abuse.

§ 5 – Penalties for Unauthorized Use of Rate Increases Earmarked for Nursing Home Staff Wage Enhancements
Effective May 31, 2022

This Section establishes that nursing home facilities that (1) receive a rate increase for wage enhancements for facility employees and (2) fail to use that rate increase for such purpose, may be subject to a civil penalty in addition to other applicable rate decrease or recoupment remedies under law.

Upon completion of an audit conducted in accordance with a facility's Medicaid provider enrollment agreement, DSS may impose a civil penalty on a facility that is found to have misused its rate increase. A civil penalty imposed on a facility cannot exceed 50% of the total dollar amount of the misused rate increase.

Additionally, this Section grants DSS with the sole discretion to facilitate a recoupment schedule with a nursing home facility to avoid a negative impact on patient care. Facilities subject to a civil penalty pursuant to this Section may request a rehearing.

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The Section applies to all wage enhancement rate increases that nursing home facilities receive pursuant to Section 323 of Public Act 21-2 (June Special Session).

§§ 6-9 – Certificates of Need for Long-Term Care Facilities

These Sections make various changes to existing law concerning CONs for nursing homes and RCHs, as well as licensed residential facilities for persons with intellectual disability that are certified to participate in the Title XIX Medicaid program as intermediate care facilities for individuals with intellectual disabilities.

§ 6

Section 6 amends the current statute (C.G.S. § 17b-352) governing CONs for additional services, bed reductions, closures and bed relocations to require that when evaluating a CON request to relocate a licensed nursing facility to another licensed nursing facility, a new facility or a replacement facility, the Commissioner of DSS must consider whether (i) a priority need identified in DSS's strategic plan to rebalance long-term care services and supports is met and (ii) whether each of the following are true: (a) no new Medicaid certified beds are added; (b) at least one (1) currently licensed facility is closed in the transaction as a result of the relocation; (c) the relocation is done within available appropriations; (d) the facility participates in the Money Follows the Person demonstration project; (e) the availability of beds in the area of need will not be adversely affected; (f) the CON approval for such new facility or relocation and the associated capital expenditures are obtained pursuant to the requirements of existing law; and (g) the facilities included in the bed relocation and closure are in accordance with DSS's strategic plan. This Section authorizes DSS to hold an informal conference during a CON review to discuss the CON application with the facility. This also permits the Commissioner to impose conditions, as deemed necessary, to address specified concerns, on any decision approving or modifying a request for a CON. Such conditions may include but are not limited to, project and Medicaid reimbursement details and applicant requirements for summary and audit purposes. Note that if the Commissioner modifies a facility's CON request, the Commissioner must notify the facility of any modifications prior to issuing the decision and must provide the facility with an opportunity to discuss the modifications in an informal conference.

§ 7

Section 7 amends the statute (C.G.S. § 17b-354) governing CONs for capital expenditures exceeding (i) $2 million or (ii) $1 million when facility square footage will be increased by more than 5,000 square feet or 5% of the existing square footage, whichever is less. This Section permits DSS to also hold an informal conference with a facility to discuss their CON application prior to a public hearing. This Section adds that if the hearing is conducted by a designee of the Commissioner who recommends denial of the CON request, then the designee must issue a

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proposed final decision in accordance with Administrative Procedure Act requirements governing agency proceedings and proposed final decisions; the Commissioner will then grant, modify or deny the request. The Commissioner may also place conditions, as deemed necessary, on the decision to approve or modify a CON request; in these circumstances, such conditions may include, however, are not limited to, project and Medicaid reimbursement details and applicant requirements for summary and audit purposes.

Section 7 also specifies that the Commissioner of DSS, or the Commissioner's designee, must now hold the public hearing at the facility for CON applications for closures or bed reductions no more than thirty (30) days after the receipt of the CON application. The Commissioner or the designee must also provide the facility and the public with notice of the date of the hearing at least ten (10) days in advance of the hearing. Lastly, the Commissioner or their designee may now send notice of such hearing to the facility through electronic mail or first-class mail.

§ 8

Section 8 amends the statute (C.G.S. § 17b-354) that sets forth exceptions to the State's moratorium on new nursing home beds in several respects. First, it amends the exception related to nursing home beds for continuing care facilities by removing the requirement that the ratio of proposed nursing home beds to the continuing care facility's independent living units be within applicable industry standards in order for DSS to accept or approve any additional nursing home beds associated with a continuing care facility. Second, the Section clarifies that the exception related to Medicaid bed relocations applies to replacement facilities. Third, this Section adds a new moratorium exception providing that DSS may approve requests to build nontraditional, small-house style nursing homes designed to enhance the quality of life for nursing facility residents where the facility agrees to reduce its total number of licensed beds by a percentage determined by the Commissioner in accordance with DSS's strategic plan for long-term care.

§ 9

Section 9 modifies the statute (C.G.S. § 17b-355) setting forth the criteria for the DSS Commissioner's evaluation of CON requests. The Commissioner shall no longer consider the relationship of the request to the state health plan or to the cost-effectiveness of health care delivery. Rather, two new considerations for the Commissioner are (1) the cost-effectiveness of the delivery of long-term care in the region and (2) the effect of the proposal on the utilization statistics of other facilities in the CON applicant's service area. Existing considerations, including but not limited to, financial feasibility, Medicaid rate impact and the business interests of owners. Section 9 also removes the requirement that the Commissioner's decision include a written explanation in cases where granting, modification or denial of a request is inconsistent with the state health plan. In addition, Section 9 deletes the requirement that the Commissioner only

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consider the need for beds for current and prospective residents of a continuing care facility when considering whether there is a clear public need for any request for additional nursing home beds. Finally, in the consideration of whether there is a clear public need for a request to relocate beds to a replacement facility, this Section now requires the Commissioner to also consider whether the availability of beds in the CON applicant's service area will be adversely affected.

Section 9 mandates that a proposal to relocate nursing home beds from an existing facility to a new facility shall not increase the number of Medicaid certified beds and that such proposal will result in the closure of at least one currently licensed facility. The Commissioner may request that an applicant seeking to replace an existing facility reduce its number of beds in the new facility by a percentage consistent with DSS's strategic plan for long-term care. Furthermore, if an applicant seeking to replace an existing facility with a new facility owns or operates more than one nursing facility, the Commissioner may request that the CON applicant close two or more facilities before approving the proposal to build a new facility.

Finally, Section 9 requires the Commissioner to also consider whether the CON application proposes a nontraditional, small-house style nursing facility and incorporates goals for nursing facilities as referenced in DSS's strategic plan for long-term care, including but not limited to: (1) promoting person-centered care; (2) providing enhanced quality of care; (3) creating community space for all nursing facility residents; and (4) developing stronger connections between the nursing facility residents and the surrounding community.

3. PUBLIC ACT 22-57. AN ACT CONCERNING TEMPORARY NURSING SERVICES AGENCIES, REPORTING OF INVOLUNTARY TRANSFERS AND DISCHARGES FROM NURSING HOMES AND RESIDENTIAL CARE HOMES, ELDER ABUSE TRAINING, LEGAL RIGHTS OF LONG-TERM CARE APPLICANTS AND A STUDY OF MANAGED RESIDENTIAL COMMUNITY ISSUES.
Effective July 1, 2022, except as otherwise noted

Temporary Staffing Agency Reforms:

The following sections establish requirements (and make related conforming changes to statutes) related to temporary staffing agencies for nursing.

§ 1

This Section defines a "health care facility" as a hospital, nursing home facility or RCH as such terms are defined in existing law. "Nursing personnel" is defined under this Section as (i) an APRN, a licensed practical nurse, or an RN licensed or issued a temporary permit to practice or

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(ii) a registered nurse's aide. "Temporary nursing services" is defined as those services provided to a health care facility on a per diem or another temporary basis. And a "temporary nursing services agency" is defined as a person or organization engaged for hire in the business of providing temporary nursing services to a health care facility (but specifically excludes individuals who only offer their own temporary nursing services).

This Section requires the Commissioner of DPH to develop a system for temporary nursing services agencies to register annually with DPH by October 1, 2022. An annual registration fee not to exceed $750 may be assessed. Notably, after January 1, 2023, no temporary nursing services agencies will be allowed to provide temporary nursing services in this State unless they are registered in accordance with this Act.

This Section also grants the Commissioner of DPH, in consultation with the Commissioner of DSS, the authority to establish requirements for temporary nursing services, including minimum qualifications for nursing personnel provided by the agency. Each temporary nursing services agency will be required to submit an annual cost report for the previous calendar year beginning no later than July 1, 2023. The contents of the report will be prescribed by the Commissioner of DPH and may include, but not be limited to, the following: (1) itemized revenues and costs; (2) the average number of nursing personnel employed by the agency; (3) average fees charged by personnel and facility type, respectively; (4) the states of the permanent residences of nursing personnel supplied by the agency to health care facilities in this State, aggregated by type of nursing personnel; and (5) other information required by the Commissioner of DPH. Each agency must make records, books, reports and other data available to the Commissioner of DPH upon request, but such records will not be considered public records for purposes of the State's Freedom of Information statutes.

The Commissioner of DPH is authorized to adopt regulations to implement this Section and may also adopt policies and procedures to implement its requirements in advance of adopting regulations provided that notice is posted on the eRegulations System within twenty (20) days of the adoption of the policies and procedures.

§ 2

This Section requires all temporary nursing services agencies to enter into a written agreement with each health care facility where its nursing personnel are assigned. Any agreement entered into, renewed or amended after July 1, 2022, must contain an assurance that the assigned nursing personnel possesses proper credentials. Furthermore, the agreement must be on file at both the temporary nursing services agency and the health care facility within fourteen (14) days of the date of assignment. A health care facility that fails to have the written agreement on file may be subject to disciplinary action.

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The requirements of this Section do not apply to health care facilities or their subsidiaries that supply temporary nursing services only to their own facility and do not charge a fee to such facility.

§ 3

This Section outlines remedies for persons aggrieved by any action of a temporary nursing services agency. Such remedies include petitioning the superior court in the judicial district in which services were rendered for relief, including temporary and permanent injunctions, as well as the ability to bring a civil action for damages.

A temporary nursing services agency that violates the provisions of Sections 1 or 2 may be assessed a civil penalty by the court not to exceed $300 for each offense. Each violation will be considered a separate and distinct offense and each day that a violation persists will be deemed a separate and distinct offense. The Commissioner of DPH may request that the Attorney General bring a civil action for injunctive relief to restrain further violations of this Act.

§ 4

This Section stipulates that the Commissioner of DSS, in consultation with the Commissioner of DPH, shall evaluate the rates charged by a temporary nursing services agency to a nursing home facility to ensure that nursing home facilities have adequate nursing personnel. By October 1, 2023, the Commissioner of DSS must submit a report to the Joint Committees of the General Assembly on Aging, Human Services and Public Health, with recommendations based on the cost reports submitted by the temporary nursing services agencies. The report may include, but need not be limited to, recommendations on changes needed in the regulation of rates charged and on how best to ensure, within available appropriations, that a nursing home facility is able to maintain adequate nursing personnel during a public health emergency.

§§ 5-6

These Sections make non-substantive, conforming changes to the requirements of existing law concerning rates of payment to nursing homes, chronic disease hospitals associated with chronic and convalescent homes, rest homes with nursing supervision, RCHs and residential facilities for persons with intellectual disabilities to remove mention of the terms “nursing pool” and “nursing pool employee” and replace them with “nursing personnel supplied by a temporary nursing services agency” instead along with other grammatical technical changes.

§ 7

This Section makes non-substantive, conforming changes to the requirements of existing law concerning acuity-based methodology for Medicaid reimbursement of nursing home services to

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remove mention of the term "nursing pool" and replace them with "nursing personnel supplied by a temporary nursing services agency" instead along with other grammatical technical changes.

§ 15 – Temporary Staffing Agency Reforms (*Conforming Changes*)

This Section repeals statutes previously in place governing nursing pools.

Electronic Reporting to the LTCO:

§ 9

This Section requires nursing home facilities to electronically report each involuntary transfer or discharge to the LTCO. Reports must be made in the manner prescribed by the LTCO and on a website maintained by the LTCO in accordance with the patient privacy provisions of HIPAA.

§ 10
Effective May 23, 2022

This Section requires RCHs to report each involuntary transfer or discharge to the LTCO in the manner described in Section 9 (above) no later than six (6) months after the effective date of this Section.

Study of Managed Residential Community Issues:

§ 11
Effective May 23, 2022

This Section requires the LTCO to appoint and convene a working group of no more than eight (8) members to study issues relevant to managed residential communities that is not affiliated with continuing care facilities. These issues include, but are not limited to, what notice should be provided to residents of managed residential communities of rental and other fee increases that exceed certain percentages and resident health transitions and determinations of care levels.

The working group must include the LTCO (or designee) and representatives from the following groups: (i) the Connecticut Assisted Living Association, (ii) Connecticut Association of Health Care Facilities/Connecticut Center for Assisted Living and (iii) LeadingAge Connecticut. The first meeting of the group must be held within sixty (60) days of this Section's effective date. The LTCO or designee shall be a chairperson along with another member of the working group chosen by its members. The administrative staff of the Joint Committee of the General Assembly on Aging will serve as administrative staff for the working group.

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The working group will submit a report of its findings to the General Assembly's joint committee on Aging by December 31, 2022. The working group will terminate on the date it submits the report or December 31, 2022, whichever is later.

Mandated Reporter of Elder Abuse Training:

§§ 12-13, as amended by Public Act 22-58, §§ 71-72
Effective May 23, 2022

Sections 12 and 13 require mandatory reporters of elderly abuse, neglect, exploitation and abandonment to complete the training program developed by the Commissioner of DSS or an alternate training program approved by the Commissioner, no later than December 31, 2022, or not later than ninety (90) days after such person becomes a mandatory reporter. Of note, Sections 71 and 72 of Public Act 22-58 (*full summary follows*) extended the December 31, 2022, deadline for training to June 30, 2023. Any mandatory reporter who has received training from an institution, organization, agency or facility that is already required to provide such training under existing law is not required to also complete the DSS training.

Long-Term Care Medicaid Application Assistance:

§ 14
Effective May 23, 2022

This Section requires DSS to develop an advisory for medical assistance applicants for long-term medical care and home care regarding their right to seek legal assistance. The advisory must state, at a minimum, that applicants are not required to hire an attorney but obtaining legal advice before completing the medical assistance application may help protect their finances and rights. The advisory must be made available and posted by July 1, 2022, on DSS's website and shall be included in applications for long-term medical care and home care no later than September 1, 2023.

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III. DEPARTMENT OF PUBLIC HEALTH

4. PUBLIC ACT 22-58. AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS REGARDING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES.
Effective as noted

§ 10 – Strike Contingency Plans
Effective July 1, 2022

This Section adds new information that health care institutions must include when filing strike contingency plans in the event of labor strikes. Specifically, it requires that all strike contingency plans include the following:

- Staffing plans for (at least) the first three (3) days of the strike; and
- The names and titles of individuals who will be providing services at the institution throughout the strike.

§ 11 – Nursing Home Administrator Continuing Education
Effective May 23, 2022

This Section adds training in infection prevention and control to the existing continuing education requirements for nursing home administrators as part of the required forty (40) hours of training every two (2) years. Accordingly, this Section adds the Association for Professionals in Infection Control and Epidemiology to the list of organizations approved to offer continuing education courses.

§§ 12-13 – Medication Administration by Unlicensed Personnel Certification
Effective October 1, 2022

Section 12 modifies the requirements for home health aides and hospice aides to be delegated with the duty of administering medications that do not require injection by a registered nurse by requiring such personnel to either have obtained certification or recertification every two (2) years (rather than every three (3) years) or to possess a current certification from the Department of Children and Families or the Department of Developmental Services.

Section 13 modifies the existing authority of the Commissioner of DPH to adopt regulations concerning RCHs' use of unlicensed personnel to administer medication to require that such personnel obtain their certification or recertification every two (2) years (rather than every three (3) years) and only from either DPH, the Department of Children and Families or the Department of Developmental Services.

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§ 36 – Social Worker Minimum Staffing Requirements in Nursing Homes Clarification
Effective May 23, 2022

This Section modifies the requirement enacted in 2021 that DPH establish staffing requirements for direct care staff, social workers and recreational staff in nursing homes to provide that the minimum social worker staffing requirement must be one (1) full-time social worker for every sixty (60) residents, minimum, applied proportionally, based upon the number of residents in the nursing home.

This Section also authorizes the Commissioner of DPH to implement policies and procedures concerning the administration of nursing home staffing requirements while in the process of adopting the policies and procedures as regulations. The Commissioner must publish notice of intent to adopt regulations on the eRegulations System within twenty (20) days of implementing any interim measures through policies and procedures. These policies and procedures will be valid until the final regulations are adopted.

§§ 37-38 – State-wide Health Information Exchange (CONNIE)
Effective May 23, 2022

These Sections amend existing law establishing the state-wide health information exchange known as "CONNIE." Under current law, nursing homes and other providers, including home and community-based services providers, will need to apply to begin the process of connecting to, and participating in, CONNIE within the next year. Both sections authorize the Executive Director of the OHS to adopt regulations to implement the statutes and permit the Executive Director to administer provisions of these Sections while in the process of adopting policies and procedures in regulation form. However, the Executive Director must hold a public hearing at least thirty (30) days before implementing the policies and procedures and publish a notice of intent to adopt the regulations on the OHS website and the eRegulations system no later than twenty (20) days after implementing the policies and procedures.

§ 46 – Involuntary Transfers and Discharges of Residential Care Home Residents
Effective October 1, 2022

This Section amends current law governing the procedures for transferring or discharging RCH residents. These revisions were developed to ensure compliance with the federal home and community-based settings rule in order to enable reimbursement for Medicaid home and community-based services provided in the RCH setting.

Notice: If a facility needs to transfer a resident involuntarily, the facility must provide written notice to the resident and, if known, to the resident's legally liable relative, guardian or

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conservator. Such notice must be given at least thirty (30) days before the transfer or discharge date, except in the event of an emergency where an immediate transfer is requested. A transfer is deemed an "emergency" if the resident poses a threat to their safety, the safety of other residents or the safety of facility personnel. This Section clarifies that an involuntary transfer or discharge of a resident will not be allowed if doing so places the resident in imminent danger of death. The facility must send a copy of the notice of transfer to the LTCO via facsimile or electronic communication on the same day it sends such notice to the resident. (Note that a separate law, also summarized in this Legislative Summary, Public Act 22-57, Section 10, requires that RCHs submit involuntary transfer/discharge notices electronically via the LTCO's portal starting on November 23, 2022 (six (6) months after the May 23, 2022, effective date).

The notice must include the following information:

- The effective date of the transfer or discharge;
- The right of the resident to appeal a transfer or discharge by the facility and information on the resident's right to represent themselves or be represented by legal counsel; and
- The name, mailing address and telephone number of the LTCO.
- If the facility knows or believes that the resident has a mental illness or disability, then the notice must also include the name, mailing address and telephone number of whomever the Governor has designated to serve as the Connecticut protection and advocacy system (currently the designated agency is Disability Rights Connecticut).

The Commissioner of DPH is authorized to change what type of information must be included in the notice.

Transfer and Discharge Plans: Facilities that have involuntarily transferred or discharged a resident are required to assist such resident with finding an alternative residence. Discharge plans must comport with DPH's requirements, address the resident's individual needs and be submitted to the resident within seven (7) days of notifying the resident of the plan to discharge or transfer them. In addition, the facility must submit its discharge plan to the Commissioner of DPH before any hearing is held regarding the discharge or transfer.

Hearings: This Section also updates how hearings are run if a resident appeals an involuntary transfer or discharge. Residents must still request a hearing within ten (10) days of receiving a transfer or discharge notice. Once the Commissioner of DPH receives the hearing request, the Commissioner must hold a hearing to determine the validity of the transfer or discharge within seven (7) days of receiving the hearing request and must issue a decision no later than twenty (20) days following the closing of the hearing record. Once an appeal is filed, the involuntary transfer or discharge is stayed pending a final decision by the Commissioner. And once a final decision is made, the Commissioner must send a copy of the final decision to the resident, the resident's

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legally liable relative, conservator or guardian or other responsible party, the facility and the LTCO.

Facilities can ask the Commissioner to make an expedited decision in the event of an emergency. To comply and make the request, the facility must submit a sworn affidavit confirming the basis upon which the emergency request is necessary. The facility must provide a copy of the request to the resident. Once the Commissioner receives the request, the Commissioner must issue a determination on the emergency request within seven (7) days of receipt of the request from the facility. The temporary order remains in effect until the Commissioner makes a final decision. In these situations, the Commissioner must hold a hearing within seven (7) days after the determination on the emergency request is made and must issue a final decision within twenty (20) days of the date on which the hearing record is closed. Once a decision has been reached, the Commissioner must send a copy of the decision to the facility, the resident, the resident's legally liable relative, conservator or guardian or other responsible party and the LTCO.

The Commissioner has the authority to determine if an emergency exists based on the information from the request. The Commissioner has the discretion to hold a hearing even if they determine that there is no emergency.

Appeals: Lastly, this Section allows a facility or resident to appeal a final decision of the Commissioner to the Superior Court. Of note, the appeal itself will not stay enforcement of the Commissioner's final decision. The Superior Court is required to consider the appeal as a "privileged case" in order to dispose of the case with the least possible delay.

§ 52 – Infection Prevention and Control Specialist Modifications
Effective July 1, 2022

This Section amends existing law enacted in 2021 so that only nursing homes and dementia special care units with more than sixty (60) residents are required to employ a full-time infection and control specialist. Facilities with (60) or fewer residents are only required to have a part-time infection prevention and control specialist. This Section does not change the duties and responsibilities of infection prevention and control specialists.

This Section also clarifies scheduling requirements for infection prevention and control specialists. Nursing homes and dementia special care units are no longer required to work rotating schedules to cover each eight-hour shift at least monthly. Instead, nursing homes and dementia special care units must require their infection prevention and control specialists to implement procedures to monitor daily shifts and ensure that they comply with infection prevention and control standards.

Furthermore, infection prevention and control specialists may provide services to both a nursing home and a dementia special care unit or to two nursing homes if: (i) the nursing and dementia

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special care unit or the two nursing homes are located next to one another or on the same campus and commonly owned or operated; and (ii) the owner or operator of the facilities submits a written request to the Commissioner of DPH (or the designee) asking whether the infection prevention and control specialist can work at both locations. Of note, the infection prevention and control specialist cannot start working at both locations until the owner/operator receives approval of the written request from the Commissioner of DPH or the Commissioner's designee.

Finally, this Section permits the Commissioner of DPH to waive any requirement in this Section so long as the Commissioner determines that doing so would not endanger the life, safety or health of residents and employees. If the Commissioner waives any requirement, the Commissioner may also impose conditions to ensure the health, safety and welfare of residents and employees. The Commissioner may also revoke the waiver upon a finding that the health, safety or welfare of any nursing home or dementia special care unit employee is jeopardized by the waiver.

§§ 53-54 – Elderly Housing Complexes with HUD Assisted Living Conversion Grants
Effective July 1, 2022

Section 53 expands the definition of "assisted living services" to also mean nursing services or assistance with daily activities provided in a housing complex that receives funds from the United States Department of Housing and Urban Development's Assisted Living Conversion Program ("HUD Assisted Living Conversion Housing Complex") in addition to existing law that only referenced managed residential communities ("MRCs") serving residents fifty-five (55) years old or older.

Section 54 permits a HUD Assisted Living Conversion Housing Complex to arrange for assisted living services with a currently licensed assisted living services agency. The HUD Assisted Living Housing Complex must inform DPH of the arrangement upon request in a form and manner set out by the Commissioner of DPH and shall not be required to register with DPH as a managed residential community. These sections provide the HUD Assisted Living Housing Complex with the flexibility to provide services either through an assisted living services agency or through other means such as the State's Home Care for Elders Program.

§ 62 – Legionella Working Group
Effective May 23, 2022

This Section requires the Commissioner of DPH to convene a working group to discuss ways to prevent and mitigate legionella in hospitals, nursing homes and other health care facilities. The group will consist of representatives from hospitals, nursing homes and water companies. The Commissioner must convene the group by July 1, 2022, and report on the findings and recommendations of the working group to the Joint Committee of the General Assembly by

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December 31, 2022. The working group will disband either on December 31, 2022, or when it issues its recommendations to the Commissioner—whichever comes first.

§§ 71-72 – Mandated Elder Abuse Reporter Training
Effective May 23, 2022

Sections 71 and 72 amend, respectively, Sections 12 and 13 of PA 22-57 (see separate summary) by extending the date by which mandatory elder abuse reporters must complete a DSS developed elder abuse training program or an alternative approved by the Commissioner of DSS to June 30, 2023, or within ninety (90) days of becoming a mandatory reporter.

§ 73 – Technical Standards for Medical Diagnostic Equipment
Effective May 23, 2022

This Section requires that, starting on January 1, 2023, when health care facilities purchase medical diagnostic equipment, they must take into consideration the technical accessibility standards developed by the Architectural and Transportation Barriers Compliance Board, a federal agency that ensures federally funded facilities are accessible for individuals with disabilities. "Health care facilities," as defined by this Act, refers to hospitals, outpatient clinics, long-term facilities (including nursing homes and RCHs) and hospice facilities. This Section also defines "medical diagnostic equipment" as an examination table, an examination chair, a weight scale, mammography equipment and x-ray, imaging and other radiological diagnostic equipment.

This Section also requires the Commissioner of DPH to notify each health care facility, physician, PA and APRN of relevant information concerning the provision of services to individuals with accessibility issues by December 1, 2022. The Commissioner must include information on the technical standards issued by the Architectural and Transportation Barriers Compliance Board. After the December deadline has passed, the Commissioner must update the aforementioned health care providers annually. The Commissioner must post the information required by this Section on its website.

§ 74 – Assisted Living Services Agencies Task Force
Effective May 23, 2022

This Section creates a task force to study assisted living services agencies that provide services to individuals living with dementia through a dementia special care unit or program. This Section requires the task force to include in its study an examination of the following:

- current regulation of these agencies by DPH and whether additional oversight is required;
- whether DPH should set minimum staffing levels for assisted living services agencies; and

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- the maintenance of records by the agencies of meals served to, bathing of and the administration of medication to residents in addition to records of the overall health of residents.

The task force must be composed of the Commissioner of DPH, or the Commissioner's designee and eight (8) other members appointed by various General Assembly leaders.

All appointments were to have been made within thirty (30) days after this Section took effect. This Section requires that the task force submit a report on its finding by January 1, 2023. The task force shall disband once it submits its report or on January 1, 2023—whichever comes first.

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IV. EMPLOYMENT

5. PUBLIC ACT 22-24. AN ACT PROTECTING EMPLOYEE FREEDOM OF SPEECH AND CONSCIENCE.
Effective July 1, 2022

This Act, colloquially known as the "Captive Audience" law, imposes significant restrictions on the right of employers (including health care employers) to educate their work forces about the decision to join a labor organization. The Act prohibits employers from threatening or subjecting employees to discipline or discharge for refusing to attend, listen to or view "captive audience meetings" (i.e., mandatory employer-sponsored meetings or communications primarily intended to convey the employer's opinion about religious or political matters).

For the purposes of this Act, "religious matters" are defined to include matters relating to religious affiliation and practice and the decision to join or support any religious organization or association; and "political matters" are defined more broadly to encompass matters relating to elections for political office, political parties, proposals to change legislation, proposals to change regulation and the decision to join or support any political party or political, civic, community, fraternal or labor organization. This Act prohibits employers, including the State, from discharging or otherwise penalizing or threatening to penalize employees who refuse to attend such meetings or listen to such communications.

Significantly, the law imposes no such restrictions on labor unions. In other words, while labor unions remain free to communicate with employees about the benefits of organizing without restriction, employers are prohibited from requiring employees to listen to contrary viewpoints and information that the unions would not provide. The Act provides for exceptions to its prohibitions on such communications which include: (i) communications required by law; (ii) communications necessary for employees to perform their job duties; (iii) academic communications to employees from institutions of higher education; (iv) communications limited to managerial and supervisory employees; (v) voluntary casual conversations between employees and employers; and (vi) exceptions for Title VII-exempt religious employers.

The Act provides that if a court finds that an employer has violated the Act, the employer will be liable to the employee for the full amount of gross loss of wages or compensation, and the court is also authorized to require payment of costs and reasonable attorneys fees.

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V. MISCELLANEOUS ACTS OF INTEREST

A. TELEHEALTH

6. PUBLIC ACT 22-81. AN ACT EXPANDING PRESCHOOL AND MENTAL AND BEHAVIORAL SERVICES FOR CHILDREN.
Effective May 24, 2022, except as otherwise noted

Sections 30-33 and 35-41 of this Act make various technical changes along with certain noteworthy updates to existing law concerning telehealth services. These revisions focus both on permanent statutes, including the telehealth statute, Conn. Gen. Stat. § 19a-906, and certain insurance statutes. They also revise Public Act 21-9, as amended by Public Act 21-133, which set forth time limited measures that were supposed to sunset on June 30, 2023, to provide greater flexibility in the use of telehealth and to mandate insurance payment parity for telehealth services during the COVID-19 pandemic; Public Act 22-81's most significant changes involve the extension of the June 30, 2023, sunset dates for Public Act 21-9's provisions by one (1) year to June 30, 2024. The detailed summary of last year's Public Act 21-9, as amended by Public Act 21-133, can be found on pp. 29-36 of the 2021 LeadingAge Legislative Summary which can be accessed *here* and, for ease of reference, the full Public Act 21-9 can be accessed *here* and the full Public Act 21-133 can be accessed *here*).

Following is a summary of the revisions within Public Act 22-81:

§ 30 – Authorizing Telehealth Services by Out-of-State Mental Health Providers as of July 1, 2024

The current statutory definition of "telehealth provider" is set out in Conn. Gen. Stat. § 19a-906 and includes a long list of providers who are licensed in this State and furnish health care or other health services through telehealth. This Section expands the definition, effective July 1, 2024, to include out-of-state providers who are "appropriately licensed, certified or registered" providers (listed below) and (i) furnish telehealth services under a relevant order issued by the Commissioner of DPH, as authorized under Section 33 of this Act (see below), (ii) provide mental or behavioral health care through the use of telehealth within such person's scope of practice and in accordance with the standard of care applicable to the profession and (iii) maintain professional liability insurance, or other malpractice insurance needed to provide telehealth services in accordance with Section 19a-906:

- Registered physician
- Naturopath
- RN
- APRN

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- PA
- Psychologist
- Marital and family therapist
- Clinical social worker
- Master social worker
- Alcohol and drug counselor
- Professional counselor
- Dietitian-nutritionist
- Nurse-midwife
- Behavior analyst
- Music therapist
- Art therapist

§ 31 – Prohibition on Hospital Facility Fees for Telehealth

This Section amends Conn. Gen. Stat. § 19a-906 to prohibit hospitals from charging a facility fee for telehealth services whether or not such telehealth services are provided on the hospital campus. The prohibition is limited to hospitals and there is no similar restriction on nursing homes or other long-term care providers.

§ 32 – Definitions of "Telehealth Services," "Telehealth Provider" and Technical Revisions

This Section amends the definition of "telehealth provider" in Public Act 21-9 to include any of the enumerated licensed providers listed in the Act without limitation (both Connecticut licensed providers and appropriately licensed out-of-state providers); previously, only "in-network" providers (a term that was not defined in Public Act 21-19) and Connecticut Medicaid providers were included in the definition. In addition, this Section amends the definition of "telehealth services" to remove limitations on use of audio-only telehealth, which was previously permitted only for "in-network" providers and Connecticut Medicaid providers. This Section also amends Public Act 21-9's provisions addressing provider payments for telehealth by limiting the total payment, including coinsurance, copayment, deductible or other out-of-pocket expenses, to the in-network amount, even if the telehealth provider is out-of-network. Finally, this Section extends various provisions enacted by Public Act 21-9, most importantly, the ability of out-of-state providers to furnish telehealth services through June 30, 2024.

§ 33 – DPH Authority to Issue Telehealth Order
Effective July 1, 2022

This Section authorizes the Commissioner of DPH to issue an order (which shall not constitute a regulation) to permit telehealth providers who are not licensed, certified or registered to practice

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in this State to provide telehealth services to patients in this State (*see* § 30 summary, *above*). The order may be of limited duration and restricted to one or more types of providers included within the definition of "telehealth provider," as amended by this Act. Additionally, the Commissioner is authorized to impose conditions, including, but not limited to, a requirement that any telehealth provider providing services pursuant to such order shall apply for licensure, certification or registration, as applicable. The Commissioner may suspend or revoke a telehealth provider's authorization to provide services upon finding that such provider has violated a condition imposed by the Commissioner or applicable law.

§§ 35-38 – Technical Revisions and Clarification on High Deductible Plans

These Sections provide for additional technical changes to last year's Public Act 21-9 such as extending until June 30, 2024, various provisions enacted by Public Act 21-9 providing temporary insurance coverage for telehealth. Moreover, Section 35 (pertaining to individual health plans) and Section 36 (pertaining to group health plans), which amend Public Act 21-9's requirements that the plans cover and pay for telehealth services, clarify that these coverage and payment requirements apply to high deductible health plans to the maximum extent permitted by federal law, unless the high deductible plan is used to establish a medical savings account, an Archer Medical Savings Account or a health savings account.

§§ 39-40 – Technical Changes to Individual and Group Health Plan Statutes
Effective July 1, 2024

These Sections amend the permanent statutes governing individual and group health plans, by requiring that, beginning July 1, 2024, the plans must cover telehealth to the same extent that they cover in-person health care services and, therefore, may not exclude a service for coverage because it is only provided through telehealth and not in-person by a provider licensed in this State.

§ 41 – OHS Telehealth Study

This Section requires the Executive Director of OHS to conduct a study concerning the provision of, and coverage for, telehealth services in this State. The study must include, but need not be limited to, the following topics:

(1) The feasibility and impact of expanding access to telehealth services, telehealth providers and coverage for telehealth services in the State beginning on July 1, 2024; and
(2) Any means available to reduce or eliminate obstacles to patient access to telehealth services and telehealth providers in the State (including, but not limited to, any means available to reduce patient costs for telehealth services and increase coverage for telehealth services in this State).

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The Executive Director must submit a report on the study's findings to the Joint Committees on Public Health, Human Services and Insurance by January 1, 2023.

B. MEDICAID ELIGIBILITY

7. PUBLIC ACT 22-121. AN ACT CONCERNING A STUDY OF THE COST AND FEASIBILITY OF PERMITTING THE COMMUNITY SPOUSE OF AN INSTITUTIONALIZED MEDICAID RECIPIENT TO RETAIN THE MAXIMUM AMOUNT OF ALLOWABLE ASSETS.
Effective May 27, 2022

This Act requires the Commissioner of DSS to study the feasibility and cost to the State of permitting the spouse of an individual institutionalized at a medical institution or nursing facility to retain the maximum amount of assets allowable by federal law under the provisions governing the Medicaid program. Permitting the spouse to retain the maximum amount of allowable assets would reduce the amount of assets that must be spent on the institutionalized spouse's medical care, likely leading to earlier Medicaid eligibility. By January 1, 2023, the Commissioner must produce a report on their findings to the Joint Committees on Aging and Appropriations.

See also: Section 235 of Public Act 22-118 increasing the community spouse protected amount.

C. PROPERTY TAX EXEMPTION

8. PUBLIC ACT 22-73. AN ACT CONCERNING PROPERTY TAX EXEMPTIONS FOR PROPERTY USED FOR CHARITABLE PURPOSES.
Effective as noted

§ 1
Effective October 1, 2022, and applicable to assessment years commencing on or after October 1, 2022

This Section modifies the existing restriction under current law concerning the eligibility for property tax exemptions for properties owned by tax-exempt entities used as: (i) orphanages; (ii) drug or alcohol treatment or rehabilitation facilities; (iii) housing for persons who are homeless, persons with a mental health disorder, persons with an intellectual or physical disability and victims of domestic violence; (iv) housing for ex-offenders and participants in programs sponsored by the Judicial Branch or the Department of Correction; or (v) short-term housing where the average length of stay is less than six (6) months. While previously the above-mentioned housing accommodations were required to be temporary, this Section makes such housing eligible for the property tax charitable exemption even if the housing is permanent and regardless of whether the organization receives housing-payments by federal, state or local governments.

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This Section also requires that assessors post the form that organizations must file every four (4) years to claim a property tax exemption on their website.

§ 2
Effective July 1, 2022, and applicable to assessment years commencing on or after October 1, 2022

This Section requires that when a board of assessors determines that property claimed to be exempt by a charitable organization is in fact taxable, the assessors must state their reasons for such determination on the record.

D. PRIVACY AND CYBERSECURITY

9. PUBLIC ACT 22-15. AN ACT CONCERNING PERSONAL DATA PRIVACY AND ONLINE MONITORING.
Effective July 1, 2023, except as otherwise noted

This Act, which is also known as the Connecticut Data Privacy Act ("CTDPA"), protects consumers by establishing a framework for controlling and processing personal data. While HIPAA covered entities and business associates, as well as federally tax-exempt organizations are *not* covered by the Act, it is useful to know about this Act's provisions, since Connecticut is only the fifth state to pass such a comprehensive data privacy law, joining California, Virginia, Colorado and Utah. Moreover, the Act requires that a designated task force (described below) study certain topics, including information sharing among health care and social services providers.

Among other things, the Act sets responsibilities and privacy protection standards for data controllers (i.e., those that determine the purpose and means of processing personal data) and data processors (i.e., those that process data for a controller). In addition, the Act empowers consumers with the right to access, correct, delete and obtain a copy of personal data and to opt out of the processing of personal data for certain purposes such as targeted advertising, the sale of personal data or profiling in furtherance of solely automated decisions that produce legal or similarly significant effects concerning the consumer. The Act also expressly prohibits a data controller from discriminating against a consumer in any way for exercising their rights under this Act.

The Act specifically applies to persons that conduct business in this State or persons who produce products or services that are targeted to residents of this State and that during the preceding calendar year either: (a) controlled or processed the personal data of not less than 100,000 consumers, excluding personal data controlled or processed solely for the purpose of completing

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a payment transaction; or (b) controlled or processed the personal data of not less than 25,000 consumers and derived more than 25% of their gross revenue from the sale of personal data.

This Act provides for several other exemptions to its applicability (summarized below):

(A) The Act does not apply to any:

i. State body, authority, board, bureau, commission, district or agency or those of its political subdivisions;
ii. Federally tax-exempt nonprofit organization;
iii. Private or public higher education institution;
iv. National securities association that is registered under federal law;
v. Financial institution or data subject to certain provisions of the Gramm Leach-Bliley Act; or
vi. Covered entities or business associates, as defined in HIPAA regulations (e.g., health plans, health care clearinghouses and health care providers who conduct standard electronic transactions).

(B) Also, the Act does not apply to the following information and data:

i. Protected health information under HIPAA;
ii. Patient identifying information associated with substance use disorder treatment;
iii. Information and documents created for the purposes of the Health Care Quality Improvement Act of 1986;
iv. Patient safety work product for the purposes of patient safety organizations under state law and the federal Patient Safety and Quality Improvement Act;
v. Information derived from any health care related information listed in the information or data exemption list that is de-identified according to HIPAA's de-identification requirements;
vi. Information originating from and intermingled to be indistinguishable with, or treated in the same manner as, other exempt information under this Act maintained by a covered entity or business associate, program or qualified service organization, as specified in federal law concerning substance use disorder treatment;
vii. Information used for public health activities and purposes as authorized by HIPAA, community health activities and population health activities;
viii. Personal data regulated by the federal Family Educational Rights and Privacy Act; and

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ix. Data processed or maintained (a) in the course of an individual applying to, employed by, or acting as an agent or independent contractor of a controller, processor, or third party, to the extent that the data is collected and used within the context of that role; (b) as an individual's emergency contact information and used for these purposes; or (c) that is necessary to retain in order to administer benefits for another individual whose data is HIPAA-protected.

This Act does not provide for a private right of action. Rather, the Act provides that the Attorney General has exclusive authority to enforce violations and that such violations will constitute an unfair trade practice under the laws of this State.

The Act also provides for certain cure provisions. For instance, from July 1, 2023, through December 31, 2024, if the Attorney General determines that a cure is possible, the Attorney General may issue a notice of violation to the controller prior to initiating an action for a violation, and the controller will have sixty (60) days from receipt of the violation to cure it. Beginning on January 1, 2025, however, the Attorney General must consider a number of factors, such as the number of violations, the size and complexity of the controller or processor and the substantial likelihood of injury to the public, in determining whether to grant a controller or processor the opportunity to cure. The Attorney General must submit a report to the Joint Committee on General Law by February 1, 2024, disclosing: (i) the number of notices of violation that has been issued; (ii) the nature of each violation; (iii) the number of violations that were cured during the sixty (60) day cure period; and (4) any other matters that the Attorney General deems relevant.

Finally, the Act requires the Chairpersons of the Joint Committee on General Law to convene a task force, no later than September 1, 2022, to provide recommendations and study the following:

(1) Information sharing among health care providers and social care providers and make recommendations to eliminate health disparities and inequities across sectors;
(2) Algorithmic decision-making and make recommendations concerning the proper use of data to reduce bias in such decision-making;
(3) Possible legislation that would require an "operator" of a website (as such term defined in the Children's Online Privacy Protection Act), upon a parent's request, to delete the account of a child and cease to collect, use or maintain, in retrievable form, the child's personal data on such website and provide the parents with a readily accessible means to make such a request;
(4) Any means available to verify the age of a child who creates a social media account;
(5) Issues concerning data colocation and the impact this Act may have on third parties that provide data storage and colocation services;

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(6) Possible legislation that would expand the provisions of this Act to include additional persons or groups; and
(7) Other topics concerning data privacy.

This Act provides that the persons serving on the task force shall include, but need not be limited to, attorneys with experience in privacy law and representatives from business, academia, consumer advocacy groups, small and large companies and the Attorney General's office. The task force must submit its report on its findings and recommendations to the Joint Committee on General Law by January 1, 2023. The task force shall be disbanded by the later of the date of submission of its report or January 1, 2023.

For more information on the CTDPA, please also see the following Advisory published by Wiggin and Dana's Strategic Sourcing and Technology Transactions practice group: Connecticut Governor Ned Lamont Signed the Connecticut Data Privacy Act ("CTDPA") - Wiggin and Dana LLP — Attorneys At Law.

E. REMOTE MEETINGS

10. PUBLIC ACT 22-3. AN ACT CONFIRMING REMOTE MEETINGS UNDER THE FREEDOM OF INFORMATION ACT.
Effective as noted

§ 1
Effective April 28, 2022

This Section modifies provisions of Public Act 21-2, June Special Session (i.e., the 2021 budget act) concerning the ability of public agencies to hold a public meeting that is accessible by means of electronic equipment or by the combination of electronic equipment and in-person attendance to remove the April 30, 2022, expiration date; thereby allowing public agencies to continue to hold remote and hybrid meetings pursuant to the requirements of existing law indefinitely.

For more details on the provisions enacted through Public Act 21-2 concerning the use of electronic communications for state proceedings, please access our more detailed summary of Section 149 of Public Act 21-2 on p. 2 of the 2021 LeadingAge Legislative Summary *here* and, for ease of reference, the full Public Act 21-2 can be accessed *here*).

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F. HEALTH CARE / TRAINING

11. SPECIAL ACT 22-9. AN ACT EXPANDING TRAINING PROGRAMS FOR CAREERS IN HEALTH CARE.
Effective May 23, 2022

§ 1

This Section establishes an initiative for the Office of Workforce Strategy, working in conjunction with various state educational institutions and state agencies, including DPH and DOL, as well as the Connecticut Hospital Association, to address the health care workforce shortage in the State. Efforts include expanding academic programs geared towards promoting increased enrollment and retention, developing alternative programs to assimilate displaced workers and individuals seeking to change careers into the health care workforce, the recruitment and retention of underserved populations and the development of distance learning and on-the-job training programs. The Chief Workforce Officer shall report to the Joint Committees of the General Assembly on Higher Education and Employment Advancement, Public Health and Labor and Public Employees on the status of the initiative no later than January 1, 2024.

§ 2

This Section calls on the Chief Workforce Officer, in collaboration with members of the Connecticut Hospital Association, community-based professional nursing organizations and representatives of the nursing home industry, the emergency medical service industry and assisted living associations, to develop a plan to work with high schools to encourage students to pursue careers in the medical field. The Chief Workforce Officer shall submit the plan to the Joint Committee of the General Assembly on Higher Education and Employment Advancement no later than January 1, 2023.

G. SENIOR MALNUTRITION

12. PUBLIC ACT 22-32. AN ACT CONCERNING DATA COLLECTION TO PREVENT MALNUTRITION AMONG SENIOR CITIZENS.
Effective July 1, 2022

§ 1

This Section requires the State's five (5) area agencies on aging to also distribute and collect nutritional risk assessment surveys from older persons in their respective service areas and to report both individual and average survey scores to the Department of Aging and Disability Services.

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§ 2

This Section requires the Department of Aging and Disability Services, in consultation with the five (5) area agencies on aging, to evaluate the sufficiency of the methodologies used under current law to allocate funding for elderly nutrition services. The evaluation concerning elderly nutrition services must take into account factors, for each of the area agencies on aging, including the average and individual nutritional risk assessment scores from the surveys mandated by Section 1 of this Act and the elderly population data made available from the latest United States Census. As a part of the evaluation process mandated by this Section, the Department must also solicit information and recommendations from elderly nutrition program providers.

This Section further requires that by July 1, 2023, the Department of Aging and Disability Services must report to the Joint Committees on Aging, Appropriations and Human Services on the data collected from their evaluations. The Department must also report on the data concerning meals on wheels providers such as the rates of reimbursement to each meals on wheels provider relative to their costs for providing meals, the administrative costs of each meals on wheels provider and the number of meals on wheels providers who have reduced or eliminated deliveries due to inadequate reimbursement by the State. Finally, the report must include any other recommended changes in the methods of allocating state funds.

H. COMMUNITY OMBUDSMAN PROGRAM

13. PUBLIC ACT 22-146. AN ACT CONCERNING ADDITIONAL ADJUSTMENTS TO THE STATE BUDGET FOR THE BIENNIUM ENDING JUNE 30, 2023, A COMMUNITY OMBUDSMAN PROGRAM, CERTAIN MUNICIPAL-RELATED PROVISIONS, SCHOOL BUILDING PROJECT GRANTS AND HIGH-DEDUCTIBLE HEALTH PLANS.
Effective July 1, 2022

§ 7

This Section establishes a Community Ombudsman program within the independent Office of the LTCO. The LTCO must appoint a Community Ombudsman no later than October 1, 2022. The Community Ombudsman must have access to data pertaining to long-term services and supports provided by a home care provider to a client, provided (1) the client or their authorized representative provides written consent to such access, or (2) if the client is unable to provide consent and has no authorized representative, the Community Ombudsman determines the data is necessary to investigate a complaint concerning the client's care.

This Section includes the following definitions for the terms used throughout this Section: (i) "authorized representative" means a person designated by a home care client, in writing, to act on

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such client's behalf, including, but not limited to, an appointed health care representative; (ii) "home care" means long-term services and supports provided to adults in a home or community-based program administered by DSS; (iii) "home care provider" means a person or organization, including, but not limited to, (a) a home health agency or hospice agency, or (b) a homemaker-companion agency; and (iv) "long-term services and supports" means (a) health, health-related, personal care and social services provided to persons with physical, cognitive or mental health conditions or disabilities to facilitate optimal functioning and quality of life, or (b) hospice care provided to persons who may be nearing the end of their lives.

The Community Ombudsman program may identify, investigate, refer and resolve complaints about home care services. Additionally, the program is intended to foster public awareness about home care, promote access to home care services and provide coaching in self-advocacy and referrals to home care clients for legal, housing and social services.

The LTCO is responsible for the overseeing of the Community Ombudsman program and as such is required to provide administrative and organizational support for the Community Ombudsman program including generating community awareness, securing funding, collaborating with other State programs, advocating for improvements in the home and community-based long-term services and supports system and recommending changes in federal, state and local laws regarding home care.

The LTCO is required to submit a report to the Joint Committees of the General Assembly on Aging, Human Services and Public Health by December 1, 2023, and annually thereafter, on the implementation of the public awareness strategy of the Community Ombudsman program, the reach of the program, the volume of complaints regarding home care received, the disposition of the complaints and any gaps in services and resources needed to address them.

Finally, the LTCO and the Community Ombudsman shall ensure that any health data is protected in accordance with the patient privacy provisions of HIPAA.

See note under summary of Public Act 22-118, section 243, which was enacted prior to this Section and authorized appointment of both the Community Ombudsman supervisor and up to twelve (12) regional ombudsmen. The reference to regional ombudsmen was not included in this Section.

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