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

2024

REGULAR SESSION OF THE CONNECTICUT GENERAL ASSEMBLY

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TABLE OF ACRONYMS

ALSA	Assisted Living Services Agency
APRN	Advanced Practice Registered Nurse
CCNH	Chronic and Convalescent Nursing Home
CHESS	Connecticut Housing Engagement and Support Services
CONNIE	Statewide Health Information Exchange
CRT	Complex Rehabilitation Technology
ADS	Department of Aging and Disability Services
DCP	Department of Consumer Protection
DESPP	Department of Emergency Services and Public Protection
DMHAS	Department of Mental Health and Addiction Services
DPH	Department of Public Health
DSS	Department of Social Services
HCBS	Home and Community Based Services
LPN	Licensed Practical Nurse
LTCO	Long-Term Care Ombudsman
MRC	Managed Residential Community
NHMC	Nursing Home Management Company
OHA	Office of the Healthcare Advocate
OHS	Office of Health Strategy
OPM	Office of Policy Management
RCH	Residential Care Home
RN	Registered Nurse
VN	Vocational Nurses

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I. ACTS AFFECTING NURSING HOMES, ASSISTED LIVING SERVICES AGENCIES, AND HOME HEALTH CARE AGENCIES

1. PUBLIC ACT 24-17. AN ACT CONCERNING NURSING HOME WAITING LISTS.
Effective May 14, 2024

This Act amends and modernizes various provisions of C.G.S. § 19a-533 (the "Waiting List Law"), which applies to nursing homes that participate in the Medicaid program and is aimed at prohibiting discrimination against indigent persons (defined as individuals eligible for, or receiving, Medicaid assistance) in the nursing home admissions process. Following is a summary of the Act's amendments:

- **Substantially Completed Application.** The Act clarifies that applicants must be placed on the waiting list upon acceptance of a "substantially completed" application for admission. Acceptance of the substantially completed application will trigger the existing requirement to provide a receipt to the applicant stating the date and time the application was accepted.
- **Flexibility on How Application is Made Available.** The Act permits facilities to provide admission applications by mail, electronic transmission or web site posting.
- **Electronic Waiting List.** Nursing homes may now maintain the waiting list in electronic form (as of the May 14, 2024 effective date), but *by July 1, 2025, all nursing homes subject to the Waiting List Law must maintain their waiting list in electronic form.*
- **New Policies and Procedures.** Nursing homes must develop and implement policies and procedures that address:
    - What information is required for a "substantially completed" and accepted application,
    - What steps will be needed to protect the privacy of information that the prospective resident submits and
    - A description of how the integrity of information in the electronic waiting list will be maintained, including steps taken to ensure accuracy in recording (1) the date and time that an applicant is placed on the waiting list and (2) any dated notification made when the prospective resident's name is passed over and another applicant is admitted.
- **Inquiry List Not Required.** The Act clarifies that a nursing home is no longer required to maintain a separate "inquiry list" for prospective residents who have not yet submitted a substantially completed application. In addition, the nursing home is not required to provide such individuals a receipt when they make an inquiry.
- **Ability to Use Electronic Mail to Communicate with Applicants About Remaining on the Waiting List.** The Act amends statutory provisions outlining the procedures by which a nursing home may inquire about an applicant's interest in remaining on the waiting list by permitting such communications to be made through electronic mail.
- **Documentation When Applicant is Passed Over.** The Act requires that whenever a nursing home passes over an applicant's name on the waiting list and admits another applicant, the nursing home must make a dated notation on the waiting list indicating why the applicant who was passed over was not admitted.

- **Daily Log Requirement.** The Act replaces the requirement that nursing homes record information daily regarding the number of patients who are on Medicare, Medicaid and private pay in a daily log or separate roster. Instead, nursing homes can maintain an electronic record of such information.
- **Access to DSS and LTCO to Investigate Complaints.** The Act requires that a nursing home provide access, when requested, to DSS or the LTCO for the purpose of investigating a complaint by or on behalf of an applicant related to the denial of their admission.

2. PUBLIC ACT 24-34. AN ACT CONCERNING ABSENTEE VOTING FOR CERTAIN PATIENTS OF NURSING HOMES.
Effective May 21, 2024

This Act modifies existing law allowing an absentee ballot applicant to appoint a designee to deliver the ballot to the applicant within six (6) days immediately preceding the close of polls in an election, primary or referendum. The Act expands the category of eligible applicants for such designation to include nursing home residents.

3. PUBLIC ACT 24-141. AN ACT PROMOTING NURSING HOME RESIDENT QUALITY OF LIFE.
Effective June 4, 2024, except as otherwise noted

§ 1 – Nursing Home Room Capacity Limitations

This Section amends existing law related to bed positioning in nursing homes and requires that by July 1, 2026, nursing homes and rest homes with nursing supervision can no longer place newly admitted residents in rooms with more than two (2) beds. A violation of this capacity restriction will constitute a Class B violation which carries a maximum civil penalty of $10,000. There is a maximum of one (1) violation per newly admitted resident per calendar year.

This Section also allows for the Commissioner of DSS to recalculate the Medicaid rate for nursing homes and rest homes with nursing supervision for the fiscal year ending June 30, 2026 and onwards, to account for any licensed bed reductions associated with the elimination of three and four-bed rooms. Additionally, the allowable fair rent must account for the costs related to building alterations or other additions incurred for fiscal year 2025 and onwards associated with the elimination of three and four-bed rooms.

§ 2 – Acceptance of Residents from Closing Nursing Homes
Effective July 1, 2024

This Section amends the nursing home waiting list statute by imposing a new waiting list exemption. The Act amends the statute, which permits a nursing home to admit a qualifying resident who is transferring as a result of nursing home closure, regardless of the waiting list, to now mandate that residents be admitted from a closing nursing home without regard to the waiting

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list, under certain circumstances. Currently, qualifying applicants include those who seek to transfer from a nursing home in which the applicant was placed following a nursing home closure if (a) the transfer takes place within sixty (60) days of the resident's transfer from the nursing home where the resident previously resided and (b) the resident previously applied for admission to the nursing home at the time they were being transferred from the nursing home where they previously resided. The requirement to have previously applied to the nursing home at the time of transfer does not apply to applicants who were emergently transferred from a nursing home that was closing.

Nursing homes are not required to admit an applicant from a closing nursing home if the nursing home has determined that (a) the applicant does not have a payor source because the applicant was denied Medicaid eligibility or the applicant failed to pay a nursing home that is closing for three months prior to the date of the admission application and has no pending Medicaid application, (b) the applicant is subject to a Medicaid penalty period or (c) the applicant does not require nursing home level of care. The Act further provides that nursing homes that qualify for a waiting list exemption when thirty percent (30%) or fewer of their residents are self-pay residents or when the vacancy is in a private room are only required to admit an indigent person from a nursing home that is closing if the resident is being transferred due to an emergency.

§§ 3 & 4 — Discontinuation of Rest Home with Nursing Supervision Licenses

Beginning June 4, 2024, the Commissioner of DPH will no longer issue any new licenses, which includes the renewal of an existing license, for rest homes with supervision. However, the Commissioner of DPH can approve a one-time, one-year renewal of an existing license expiring on or after June 4, 2024 if the rest home meets renewal requirements. Denials of these renewals may not be appealed.

A facility that changes its licensure from a rest home with nursing supervision to a chronic and convalescent nursing home is exempt from requesting permission from DSS, as is currently required when transferring, adding, expanding, increasing, terminating, decreasing or relocating facility beds.

§ 5 — Nursing Facilities and State Enforcement Authority

This Section modifies and extends DPH and DSS' authority under C.G.S. § 17b-357 to take enforcement action against nursing homes that participate in Medicaid if found to be in violation of federal law, to now allow such enforcement actions to also be taken for violations of state statutory and regulatory requirements.

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§ 6 — Penalties for Healthcare Institutions Failing to Comply with Corrective Action Plans

This Section amends the law by allowing DPH to impose disciplinary action against any DPH-licensed institution that fails to comply with an accepted plan of correction. Potential disciplinary actions for failure to comply include revocation, suspension, or censure of a license or certificate, issuance of a letter of reprimand, probation which would require reporting regularly to DPH, restricting acquisition of the facilities for a predetermined time period, issuing an order compelling compliance, imposing a directed plan of correction, or imposing civil penalty of up to $25,000 in qualifying circumstances.

§§ 7-8 — Managed Residential Community Residency Agreements and Fee Disclosure
Effective June 4, 2024 and October 1, 2024, respectively

Section 7 makes various changes to the MRC residency agreement requirements. The Act requires that in addition to the existing requirement for written residency agreements to include a full disclosure of all charges, fees and costs incurred by MRC residents, beginning October 1, 2024 residency agreements must also disclose nonrefundable charges, fees, expenses and costs. In addition, MRC written residency agreements entered into as of October 1, 2024, must disclose the manner in which the MRC may adjust monthly fees or other recurring fees, including but not limited to (a) how often fee increases may occur, (b) the schedule or specific dates of the increases and (c) a record of fee increases over the past three (3) calendar years.

Section 8 imposes new resident notice and reimbursement requirements for MRCs. Beginning October 1, 2024, MRCs will be required to provide ninety (90) days' advanced notice to residents and their representatives of any increase to the monthly or recurring fees and written disclosure of nonrefundable charges. MRCs will also be required to reimburse residents, on a prorated basis or fully, for certain charges if the MRC determines within the first forty-five (45) days after the resident's occupancy, that the MRC cannot meet the resident's needs. The resident must be reimbursed charges including, but not limited to, prorated first month's rent, prorated community fee, full last month's rent and full security deposit.

The following types of MRCs are exempt from the requirements imposed under Sections 7 and 8: (a) elderly housing complex receiving funding from the U.S. Department of Housing and Urban Development's Assisted Living Conversion program and (b) the State of Connecticut's demonstration project for the provision of subsidized assisted living services.

§ 9 — ALSA Fee Increase Disclosure
Effective October 1, 2024

This Section requires ALSAs to disclose all fee increases to residents or their representatives no more than sixty (60) days prior to the fees taking effect. Section 9 also imposes a new requirement that upon the request of a resident or their representative, ALSAs must provide the history of fee

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increases over the past three (3) calendar years. ALSAs are permitted to implement immediate fee adjustments if they are directly related to a change in the level of care or services necessary to meet resident safety needs, as determined at a scheduled resident care meeting or upon a change of condition that requires a change in services.

§§ 10-11 — Appointment of Receivers of Nursing Homes or Residential Care Homes

Section 10 amends the nursing home receivership statute to broaden the ability of courts to appoint a receiver on the basis of financial loss or failure. Prior to the amendment, the application to appoint a receiver was required to be granted upon a court's finding that the nursing home or residential care home actually sustained, or was reasonably likely to sustain, a serious or financial loss or failure that rose to the level of "jeopardize[ing] the health, safety and welfare of the patients." The amendment removes the quoted language so that a finding of actual or reasonable likelihood of financial loss or failure is now sufficient for a receiver to be appointed, even if there is no finding that the health, safety and welfare of residents may be jeopardized.

Section 11 amends the criteria and qualifications for receivers. Under the Act, courts may now appoint an entity to act as receiver. In addition, a receiver is no longer required to hold a nursing home administrator license, and instead can be an individual or entity that has substantial experience in delivering high-quality health care services and successful management or operation of long-term care facilities, and has the education or licensure that is customary of managers and operators of health care facilities similar to the facility subject to the pending receivership. The Act prohibits any person employed by a private equity company or entity owned or operated by a private equity company from being appointed to act as a receiver.

§ 12 — Nursing Facility Management Services

This Section amends the requirements for nursing facility management services (referred to as "nursing home management company" or "NHMC") certification in a number of ways.

Definitions

The Act defines "managed facility" as "a nursing facility that receives nursing facility management services from a nursing facility management services certificate holder."

Application for Certification

The Act reduces the disclosure threshold of the beneficial ownership interests in a NHMC from ten percent (10%) to five percent (5%). NHMC applicants must also now disclose all nursing facilities where the applicant or beneficial owner is currently or has been the owner, operator, or

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administrator in the last five (5) years, and whether those facilities have been subject to the following enforcement actions (collectively, the "Adverse Actions"):

- Three (3) or more civil penalties imposed by DPH final order or imposed by another state during the two (2) years prior to submission of the application;
- State-imposed Medicare or Medicaid sanctions, other than civil penalties of $20,000 or less; or
- Medicare or Medicaid provider agreement termination or nonrenewal.

An application for certification may be denied if DPH determines that the applicant or beneficial owner possesses an unacceptable history of past and current noncompliance with state and federal requirements, if there is evidence of (a) any of the Adverse Actions, (b) continuing violations or a pattern of violations of state licensure standards or federal certification standards, or (c) criminal conviction of, or a guilty plea by, an applicant or beneficial owner for fraud, patient or resident abuse or neglect or a crime of violence or moral turpitude.

Renewal

The Act further broadens the materials that may be required by DPH to be submitted for NHMC renewal applications, allowing DPH to require submission of any information in addition to that which is already required to be disclosed on the licensure application, departing from the prior restriction that in addition to the information on the licensure applications, DPH could only require submission of the audited and certified financial statements. The NHMC renewal application now also requires the NHMC to submit evidence of substantial compliance with federal regulatory requirements, and not just with the Public Health Code and licensing regulations, as was previously required.

Adding Nursing Home to Current Certificate

The Act requires that when a certified NHMC intends to manage a nursing home it is not currently managing, the NHMC must seek DPH approval by filing an application with DPH thirty (30) days prior to providing management services at the facility. DPH may deny the application based on the NHMC's prior compliance history.

Enforcement

The Act broadens the ability of the Commissioner of DPH to take disciplinary action against NHMCs. The Commissioner of DPH may now impose disciplinary action against the NHMC where the Commissioner of DPH finds that there has been (a) a substantial failure by one (1) or more facilities managed by the NHMC to comply with state licensure or federal and state regulatory requirements, or (b) a substantial failure by the NHMC managing those facilities to comply with the requirements of the NHMC certificate requirements. If three (3) or more facilities

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managed by the certified NHMC are subject to civil penalties imposed through final order of the Commissioner of DPH during a twelve (12) month period, the Commissioner of DPH is permitted to impose a civil penalty on the NHMC of up to $20,000 following an administrative hearing.

Similar to the amendments in Section 6 of the Act, the failure of a NHMC to comply with a plan of correction accepted by DPH could result in disciplinary action under C.G.S. § 19a-494 including revocation, suspension, or censure of a license or certificate, issuance of a letter of reprimand, probation which would require reporting regularly to DPH, restricting acquisition of the facilities for a predetermined time period, issuing an order compelling compliance, imposing a directed plan of correction, or imposing civil penalty of up to $25,000 in qualifying circumstances.

§ 13 — Nursing Home Bed Reduction Working Group

This Section requires that a working group be established to study the impact of the prohibition implemented in Section 1 of this Act, on placing a newly admitted resident in a room with more than two (2) beds. While Section 1 does not mention consent in the context of the prohibition, Section 13 specifically describes the charge of the working group to focus on the impact of prohibiting placement in rooms with more than two (2) beds "without consent."

The working group must examine methods to (a) assist such facilities affected by the provisions of Section 1 of this Act, including identifying opportunities to support the financial sustainability of such facilities and (b) ensure that such facilities are able to comply with the provisions of Section 1 of this Act.

The working group must consist of members including various appointed officials and representatives of state agencies including OPM, DSS and DPH and members of the General Assembly's Aging Committee. Members of the working group were required to be appointed by July 4, 2024, and the first meeting of the working group was to be held by August 3, 2024.

The working group must submit a report of its findings and recommendations to the General Assembly's Aging Committee by January 1, 2026. The working group will terminate on the date that it submits such report or January 1, 2026, whichever is later.

II. ACTS AFFECTING VARIOUS HEALTH CARE PROVIDERS

4. PUBLIC ACT 24-19. AN ACT CONCERNING THE HEALTH AND SAFETY OF CONNECTICUT RESIDENTS
Effective October 1, 2024, except as otherwise noted

Enacted in response to an incident involving a home health employee, this Public Act imposes several new requirements to increase the safety of the home health care employee.

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§ 1 — Home Health Safety-Related Client Intake

This Section requires home health care agencies and home health aide agencies to collect certain information about prospective clients during the intake process, and then provide that information to any employee assigned to provide services to the client, to the extent feasible and consistent with state and federal laws. This requirement does not apply to hospices.

The following information is required to be collected about the prospective home health care agency client: (a) the client's history of violence toward health care workers; (b) the client's history of substance use; (c) the client's history of domestic abuse; (d) a list of the client's diagnoses, including, but not limited to, psychiatric history; (e) whether the client's diagnoses or symptoms thereof have remained stable over time; and (f) any information concerning violent acts involving the client that is contained in judicial records or any sex offender registry information concerning the client.

The following information is required to be collected about the location where the employee will provide services: (a) the crime rate for the municipality in which the employee will provide services, as determined by the most recent annual crime report issued by DESPP; (b) the presence of any hazardous materials at the location, including, but not limited to, used syringes; (c) the presence of firearms or other weapons at the location; (d) the status of the location's fire alarm system; and (e) the presence of any other safety hazards at the locations.

In addition, home health care agencies and home health aide agencies must annually review the yearly report issued by DESPP setting forth crime-related data in the locations where the agency's employees provide services. The most recent annual crime report issued by DESPP is available here.

Home health care agencies and home health aide agencies may not deny the provision of services to a client solely based on either (a) the inability or refusal of the client to provide the information requested pursuant to this Section or (b) the information collected from the client pursuant to this Section.

§ 2 — Home Health Agency Worker Safety Training and Medicaid Reimbursement

This Section requires home health care agencies and home health aide agencies to adopt and implement a health and safety training curriculum for home care workers that is consistent with the health and safety training curriculum endorsed by the Centers for Disease Control and Prevention's National Institute for Occupational Safety and Health and the Occupational Safety and Health Administration. The curriculum must include training to recognize hazards commonly encountered in home care workplaces and to apply practical solutions to manage risks and improve safety. This training must be provided annually to staff members. In addition, home health care

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agencies and home health aide agencies must conduct monthly safety assessments with direct care staff at each monthly staff meeting.

In addition, DSS must require home health care agencies and home health aide agencies that receive Medicaid reimbursement to provide evidence of adoption and implementation of the required health and safety training curriculum or, at DSS's discretion, an alternative workplace safety training program, in order to obtain Medicaid reimbursement. Note that these requirements do not apply to hospices.

DSS may also provide a Medicaid rate enhancement to home health care agencies and home health aide agencies for timely reporting of any workplace violence incident. "Timely reporting" means reporting the incident to DSS and DPH not later than seven (7) calendar days after its occurrence.

§ 3 — Home Health Reporting of Client Threats or Abuse

This Section imposes new reporting requirements on home health care agencies and home health aide agencies regarding threats to and abuse of staff by agency clients. Not later than January 1, 2025, and annually thereafter, home health care agencies and home health aide agencies will be required to report, in a form and manner prescribed by DPH, each instance of abuse by an agency client against a staff member of the agency, including (a) verbal abuse that is perceived as a threat or danger by a staff member of the agency, (b) physical abuse, or (c) sexual abuse. The home health care agencies and home health aide agencies will also be required to report any actions that they took to ensure the safety of the staff member. This requirement does not apply to hospices.

Not later than March 1, 2025, and annually thereafter, DPH must report to the General Assembly's Public Health Committee the number of such reports received and the actions taken to ensure the safety of the staff member about whom the report was made.

§ 4 — Home Health Staff Safety Grant Program

Not later than January 1, 2025, DSS must establish a home health worker safety grant program to provide incentive grants for home health care agencies and home health aide agencies. The program must begin on or before January 1, 2027, and provide (a) escorts for safety purposes to staff members conducting a home visit and (b) a mechanism for staff to perform safety checks, which may include, but need not be limited to, a mobile application that allows staff to access safety information relating to a client, a method of communicating with local police or other staff in the event of a safety emergency and a global positioning system-enabled, wearable device that allows staff to contact local police by pressing a button or through another mechanism.

DSS must establish eligibility requirements, priority categories, funding limitations and the application process for the grant program.

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Not later than January 1, 2026, and annually thereafter until January 1, 2027, DSS must report to the General Assembly's Public Health Committee on the number of home health care agencies and home health aide agencies that applied for and received an incentive grant and the use of incentive grant funds by recipients.

§ 5 — Health Care Facility Worker Safety Training and Medicaid Reimbursement

This Section imposes a new requirement for certain health care facilities that receive Medicaid reimbursement to adopt and implement workplace violence prevention standards consistent with those established by the Joint Commission or any applicable certification or accreditation agency. This requirement will apply to nursing homes as well as general and chronic disease hospitals, behavioral health facilities, multicare institutions or psychiatric residential treatment facilities, as defined in existing law at C.G.S. § 19a-490. DSS may require these health care facilities to provide evidence that such standards were adopted and implemented as a condition to receiving reimbursement for services provided under the Medicaid program.

§ 6 — Home Health Workforce Safety Working Group

This Section requires the co-chairs of the General Assembly's Public Health Committee to convene a working group to study staff safety issues affecting home health care and home health aide agencies and hospice organizations. Not later than January 1, 2025, the working group must submit a report on its findings and recommendations to the Public Health Committee.

§§ 8, 28 & 29 — Working Groups on Health Issues
Effective May 21, 2024

These Sections mandate the General Assembly's Public Health Committee to establish working groups for the following purposes: (a) to study nonalcoholic fatty liver disease, including nonalcoholic fatty liver and nonalcoholic steatohepatitis (Section 8), (b) to study and make recommendations concerning methods of addressing loneliness and isolation experienced by persons in the State and to improve social connection among such persons, including, but not limited to, through the establishment of a pilot program that utilizes technology to combat loneliness and foster social engagement (Section 28) and (c) to examine hospice services for pediatric patients across the State (Section 29).

The working groups must submit a report on their findings and recommendations to the General Assembly's Public Health Committee by January 1, 2025, except the working group examining pediatric hospice services will submit its report by March 1, 2025. The working groups, except that examining pediatric hospice services, will terminate on the later of the date that the report is submitted on or on January 1, 2025.

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§ 20 — Cybersecurity Disruption Audits
Effective May 21, 2024

This Section provides for a new requirement that by January 1, 2025, and annually thereafter, each licensed hospital, except any hospital operated exclusively by the State, must (a) submit the hospital's plans and processes for responding to a cybersecurity disruption of the hospital's operations to an audit by a certified auditor to determine the adequacy of such plans and processes and (b) confidentially make the audit results and any steps to implement recommended improvements by the auditor available to DPH, the Department of Administrative Services and DESPP. The recipient of the information must maintain its confidentiality and the information provided is exempt from disclosure under the Freedom of Information Act.

§§ 21-22 — State-wide Health Information Exchange

These Sections amend the statutes governing the state-wide Health Information Exchange, commonly known as Connie (C.G.S. §§ 17b-59d and 17b-59e). First, the statute articulating the goals of the state-wide Health Information Exchange was revised to incorporate the Federal Information Blocking regulations.

Second, a provision was added to clarify that a health care provider is not required to connect to Connie if the provider (a) possesses no patient medical records, or (b) is an individual who exclusively practices as an employee of a covered entity, as defined by HIPAA and the covered entity employer is legally responsible for decisions regarding the safeguarding, release or exchange of health information and medical records.

Third, to address concerns about sharing sensitive health information with Connie without required patient consent, a provision was added to clarify that health care providers are not required to share patient information with Connie if (a) sharing such information is prohibited by state or federal privacy and security laws, or (b) affirmative consent from the patient is legally required and such consent has not been obtained. In addition, a provision was added explicitly stating that any health care provider that would violate any other law by sharing information with or connecting to Connie must not be required to share such information with or connect to Connie.

Fourth, the revised statute provides health care providers with immunity from liability for any private or public claim related directly to a data breach, ransomware or hacking experienced by the state-wide Health Information Exchange. This immunity does not shield health care providers from liability associated with the health care provider's failure to comply with applicable state and federal data privacy and security laws and regulations in sharing information with and connecting to Connie.

Lastly, health care providers are now required to be connected to and actively participating in Connie not later than 18 months after the date of implementation of OHS policies and procedures.

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This means that eighteen (18) months after the implementation of OHS policies and procedures, health providers must be onboarded with Connie and actively sharing medical records with Connie.

§ 23 — State-wide Health Information Exchange Working Group

This Section establishes a Connie regulations and policies and procedures working group. Not later than September 1, 2025, OHS is required to establish a working group to make recommendations regarding the parameters of the regulations to be adopted by, and any policies and procedures to be implemented by, OHS regarding Connie. Not later than January 1, 2025, OHS must report the recommendations of the working group to the General Assembly's Public Health Committee.

§ 24 — State Health Information Technology Advisory Council

This Section revises the statute establishing and governing the State Health Information Technology Advisory Council (the "Council") to require that the Council include the Attorney General, or the Attorney General's designee. The Council was established to advise OHS and the health information technology officer in developing priorities and policy recommendations for advancing the State's health information technology and health information exchange efforts. The Council also advises regarding the development of appropriate governance, oversight and accountability measures to ensure success in achieving the State's health information technology and exchange goals.

§ 25 — Healthy Brain Initiative
Effective May 21, 2024

This Section mandates DPH to report on its work on the Healthy Brain Initiative to the General Assembly's Public Health Committee by January 1, 2025 and annually thereafter. "Healthy Brain Initiative" is defined to mean the National Centers for Disease Control and Prevention's collaborative approach to fully integrate cognitive health into public health practice and reduce the risk and impact of Alzheimer's disease and other dementias.

§ 26 — Parkinson's Disease Registry
Effective May 21, 2024

This Section defines (a) "health care provider" to mean any person or organization who is licensed or certified to furnish health care services to persons with Parkinson's disease or Parkinsonism and (b) "hospital", as identified in existing law, to mean "an establishment for the lodging, care and treatment of persons suffering from disease or other abnormal physical or mental conditions and includes inpatient psychiatric services in general hospitals."

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By April 1, 2026, DPH is required to collaborate with a public institution of higher education in the State to maintain and operate a state-wide registry of data on Parkinson's disease or Parkinsonism. The Commissioner of DPH must promulgate regulations to require hospitals and health care providers to share data with the registry concerning its patients with Parkinson's disease. Both the hospital and health care provider should provide each patient with notice of and an opportunity to opt out of the disclosure.

The data in the registry may be used by DPH and authorized researchers provided that a patient's personally identifiable information is kept confidential. Registry data is not subject to disclosure under the Freedom of Information Act. To implement and administer the registry, the Commissioner of DPH may enter a contract with a nonprofit association in the State concerned with the prevention and treatment of Parkinson's disease. To ensure data accuracy and completeness, hospitals must provide DPH access to their records to perform quality improvement audits. Furthermore, DPH may enter a contract for the receipt, storage, holding or maintenance of the data or files under its control and management. DPH may also enter into reciprocal reporting agreements with the appropriate agencies of other states to exchange Parkinson's disease and Parkinsonism care data.

This Section further requires DPH to establish a Parkinson's disease and Parkinsonism data oversight committee to (a) monitor the registry operations, (b) provide advice on registry oversight, (c) develop a plan to improve Parkinson's disease and Parkinsonism care and reduce care disparities and (d) develop short and long-term goals for care improvement.

By April 1, 2026, the Commissioner of DPH is required to appoint various individuals to the committee for a term of two (2) years. In addition, the Commissioner of DPH must appoint a chairperson who must schedule the committee's first meeting by April 1, 2026. The chairperson of the committee must report the committee's work to the General Assembly's Public Health Committee and to the Commissioner of DPH by January 1, 2027 and annually thereafter.

Lastly, 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. The policies and procedures are valid until final regulations are adopted.

§ 27 — Recent-Onset Schizophrenia Spectrum Disorder
Effective May 21, 2024

This Section requires the Commissioner of DMHAS to consult with the Commissioner of Children and Families to establish a specialized early treatment program for persons diagnosed with recent-onset schizophrenia spectrum disorder. The program will serve as a clearinghouse for information

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regarding early intervention services for persons diagnosed with the disorder. The program will address: (a) the limited knowledge of (1) region-specific needs in treating the disorder, (2) the prevalence of first-episode psychosis in diagnosed individuals and (3) regional treatment disparities, (b) uncertainty regarding the availability of clinicians to implement early intervention services to diagnosed individuals and their families and (c) funding and reimbursement options for early intervention services available to diagnosed individuals.

The specialized early treatment program required by this Section must perform the following functions: (a) develop curricula, including online resources, relevant to patients with first-episode psychosis and their families; (b) access and improve the quality of early intervention services available to individuals in the State diagnosed with recent-onset schizophrenic spectrum disorder; (c) provide expertise on complex cases of recent-onset schizophrenic spectrum disorder and launch a referral system for treatment of the disorder; (d) share resources from campaigns aimed at reducing the duration of untreated psychosis; (e) foster and pilot new evidence-based treatment approaches; (f) advocate for policies addressing the financing, regulation and provision of services for diagnosed individuals and (g) collaborate with state agencies to improve crisis and employment services for diagnosed individuals.

By January 1, 2025, and annually thereafter, the Commissioner of DMHAS must submit a report to the General Assembly's Public Health Committee detailing the functions and outcomes of the program and making recommendations for legislation to address the needs of diagnosed individuals.

§ 30 — Pediatric Hospice Care
Effective May 21, 2024

This Section requires that by July 1, 2025 and at the hiring of new nursing staff, each organization that is licensed as a hospice must encourage its nursing staff to spend three (3) weeks each in a pediatric intensive care unit, pediatric oncology unit and pediatric hospice facility to (a) enhance their skills and expertise in pediatric care and (b) prepare them for future roles in pediatric hospice care.

§ 31 —Direct Care Definitions for Nursing Homes
Effective May 21, 2024

This Section amends existing law establishing minimum staffing level requirements for nursing homes by providing a definition of "direct care." The Section defines "direct care" to mean hands-on care provided by a RN, LPN or a nurse's aide to residents of nursing homes, including, but not limited to, assistance with feeding, bathing, toileting, dressing, lifting and moving, administering medication, promoting socialization and personal care services. The definition further states that

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"direct care" does not include food preparation, housekeeping, laundry services, maintenance of the physical environment of the nursing home or performance of administrative tasks.

§ 32 and § 33— Clinical Peers
Effective January 1, 2026 and January 1, 2025, respectively

Existing law establishes certain requirements to qualify as a clinical peer for insurance adverse determination reviews. Section 32 amends the definition of "clinical peer" to include a physician or other health care professional who holds a license in the same specialty as the treating physician or health care professional who is managing the medical condition, procedure, or treatment under review. Section 33 newly requires health carriers to authorize clinical peers to reverse initial adverse determinations that was based, in whole or in part, on medical necessity.

§§ 34 and 35— Prior Authorization for Ambulance Services
Effective January 1, 2025

These Sections amend existing law to prohibit certain health insurance policies that were delivered, issued for delivery, or renewed in this State on or after January 1, 2025, from requiring enrollees to obtain approval from the insurer before being transported by an ambulance to a hospital when medically necessary. Under existing law, health insurance policies are already prohibited from requiring an enrollee to obtain prior authorization for calling 9-1-1 in a life-or limb-threatening emergency.

Furthermore, these Sections add a new prohibition that certain insurers and health care centers may not deny payment to any ambulance provider responding to a 9-1-1 call on the basis that the enrollee did not obtain prior approval from the insurer or health care center before either calling 9-1-1 or transporting the enrollee by ambulance to a hospital when such transportation was medically necessary.

§ 37 — Physician Recruitment Working Group
Effective May 21, 2024

This Section eliminates the date by which the Commissioner of DPH was required to convene the physician recruitment working group and extends the deadline by which the working group must submit its report to the Commissioner of DPH and the General Assembly's Public Health Committee by two (2) years, from January 1, 2024 to January 1, 2026.

This Section also adds to the working group's aim to examine issues related to primary care residency positions in the State and methods to retain physicians who perform their primary care residency in the State. As used in this Section, "primary care" is defined to mean pediatrics, internal medicine, family medicine, obstetrics and gynecology or psychiatry.

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§§ 38 & 39— Discrimination Against Nursing Home Applicants
Effective October 1, 2024

Section 38 makes it a prohibited discriminatory practice for any nursing home to deny an application for admission solely on the basis that the applicant, at any time, received mental health services. However, nursing homes are not required to admit a person if (a) they pose a direct threat to the health or safety of others, (b) they do not require the level of care provided in the nursing home or (c) admitting them would result in converting the nursing home into an institution for mental diseases.

Section 38 provides for certain defined terms many of which are already set forth in existing state and federal statutes and regulations. The following is a summary of the defined terms:

- "Direct threat" has the same meaning as provided in existing federal regulations, to mean "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices or procedures or by the provision of auxiliary aids or services."
- "Institution for mental diseases" has the same meaning as provided in existing federal regulations to mean "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services." The status of an institution as one for mental diseases is determined by its overall character and attributes, regardless of whether it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases.
- "Nursing home" has the same meaning as defined existing state law to mean "(1) any chronic and convalescent nursing home or any rest home with nursing supervision that provides nursing supervision under a medical director twenty-four hours per day or (2) any chronic and convalescent nursing home that provides skilled nursing care under medical supervision and direction to carry out nonsurgical treatment and dietary procedures for chronic diseases, convalescent stages, acute diseases or injuries."
- "Mental health services" means "counseling, therapy, rehabilitation, crisis intervention, emergency services or psychiatric medication for the screening, diagnosis or treatment of mental illness."

Section 39 amends the definition of "discriminatory practice" prohibited under the Commission on Human Rights and Opportunities ("CHRO") laws to include discrimination addressed in Section 38. By doing so, this Section allows nursing home applicants aggrieved by an alleged discriminatory practice to file a complaint with the CHRO.

Under existing Connecticut regulations, nursing homes are permitted to admit residents with manageable psychiatric conditions if, after an evaluation, a psychiatrist determines it is medically appropriate. In addition, federal regulations require Medicaid-certified nursing homes to conduct

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a preadmission screening of individuals with mental illness and intellectual disability, known as PSARR, to ensure the individuals require nursing facility-level of services. Other related federal laws, including the Americans with Disabilities Act, prohibit discrimination based on various factors, including perceived and actual disability.

§ 40 — Data on Prior Authorizations and Precertifications
Effective May 21, 2024

This Section provides that on and after January 1, 2025, hospitals, outpatient surgical facilities and group practices, as those terms are defined in existing law, may record and maintain data regarding the amount of time that an employee spends requesting prior authorization or precertification from a health carrier for a patient of the hospital, outpatient surgical facility or group practice. This includes time spent speaking directly with the health carrier, having physician peer-to-peer conversations regarding the prior authorization or precertification and writing appeals for the denial of prior authorization precertification requests. Under this Section, hospitals, outpatient surgical facilities and group practices may (a) use preauthorization and precertification codes generated by the Connecticut Hospital Association to uniformly record the data collected and (b) make the data available to the General Assembly's Public Health Committee upon request.

5. PUBLIC ACT 24-68. AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES.
Effective May 28, 2024, unless otherwise indicated

§§ 32-33 — DPH Civil Penalties
Effective July 1, 2024

Section 32 authorizes DPH to impose a civil penalty of up to $25,000 on health care institutions (which includes, but is not limited to, hospitals, nursing homes, residential care homes, ALSAs, home health care and hospice agencies) following a hearing where there was a finding of substantial failure to comply with Connecticut General Statutes Chapter 368v governing health care institutions. This civil penalty cannot be assessed for violations arising from complaints filed with DPH before July 1, 2024, unless the complaint involved a violation of a regulatory requirement related to abuse or neglect of patients. Nursing homes and residential care homes are already subject to statutory civil monetary penalties, so it is unclear how this new law will apply given the separate existing civil monetary penalty provisions and process.

Section 33 reduces the maximum civil penalty that DPH may impose upon individual practitioners, from $25,000 to $10,000.

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§ 36 — Homemaker-Companion Agency Transition to DPH Deadline Extension

This Section extends the deadline by four months for the Secretary of OPM to report a plan to transfer the oversight over homemaker-companion agencies from DCP to DPH. Under the amendment, the Secretary of OPM must now report on the plan by December 1, 2024 to the General Assembly's Aging, General Law, and Public Health Committees. The existing law requires that this plan provide (a) a timeline for the transition and (b) recommendations for appropriate training standards that promote best practices for providing homemaker companion services, provide instruction and specialized training for Alzheimer's care and ensure a high quality of care for clients. The plan may also include an evaluation and recommendation for the permissible use of the term "care" in describing homemaker-companion agency services.

§ 63 — CONNIE Working Group

This Section moves up by one (1) year the deadline for the Executive Director of OHS to establish a working group to make recommendations on the regulations, policies and procedures regarding participation in Connie. The deadline for establishing the Connie Working Group is now September 1, 2024.

6. PUBLIC ACT 24-39. AN ACT SUPPORTING CONNECTICUT SENIORS AND THE IMPROVEMENT OF NURSING AND HOME-BASED CARE
Effective October 1, 2024, except as otherwise noted

§§ 1-3 – DSS Home Care Provider Registry and Data Processing System

Section 1 of this Act requires DSS, in conjunction with DPH and DCP, to develop a home care provider registry and data processing system that can be accessed by persons who receive Medicaid covered HCBS. The home care provider registry must list individuals who provide home health care and homemaker companion services as specified below. The following is a summary of the defined terms used in the Act:

- "Home care" is defined as "long-term services and supports provided to adults in a home or community-based program administered by DSS."
- "Family caregiver" is defined as a person who provides adult family living services under the following existing programs: (a) the Connecticut home-care program for the elderly, (b) the personal care assistance program, or (c) the three programs established to provide HCBS to DSS clients.
- "Home care provider" is defined as a person who (a) provides home care or long-term services and supports and is not licensed by DPH, or (b) is employed by an entity that provides such services, including a home health agency or hospice agency or a homemaker-companion agency. This definition excludes family caregivers and personal

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care attendants who provide personal care services through DSS's personal care attendant program.

- "Long-term services and supports" is defined as (a) health, health-related, personal care and social services to facilitate optimal functioning and quality of life provided to persons with physical, cognitive or mental health conditions or disabilities, or (b) hospice care provided to persons who may be nearing the end of their lives.

Beginning January 1, 2025, the Commissioner of DSS, working with the Commissioners of DPH and DCP, must develop and maintain a home care provider registry and data processing system that promotes awareness of and access to qualified home care providers for persons who receive Medicaid-covered HCBS and that may support the recruitment and retention of qualified home care providers and oversight of home care providers. The link to this registry must be posted on the DSS website.

The home care provider registry will include the following information regarding each home care provider in the State:

(a) first and last name,
(b) job title,
(c) date of hire,
(d) employer's legal name,
(e) training programs offered by the home care provider's employer, and
(f) the date the home care provider completed any such training.

The Commissioner of DSS in consultation with the Commissioners of DPH and DCP must develop procedures for collecting and maintaining this information, including the frequency of collection and methods to update or remove inaccurate or outdated information.

A home care provider may be exempt from the reporting requirements if the provider (a) is a victim of domestic violence or sexual assault, (b) is protected by a protective order, restraining order or standing criminal protective order, or a foreign order of protection, or (c) asserts that extraordinary personal circumstances require an exemption to be granted to protect the health, safety or welfare of the home care provider. Any exemption must be asserted directly to the home care provider's employer in a form and manner prescribed by DSS. A home care provider seeking an exemption may not be required to submit proof of qualification for the exemption.

The home care provider registry may include the following functionalities:

i. Connect persons seeking HCBS with qualified home care providers by (a) helping such persons identify and match with home care providers by sorting the providers based on certain characteristics including language proficiency, certifications and prior experience or special skills and (b) assisting such persons and their families to navigate the HCBS system in the State;

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ii. Support recruitment and retention of qualified home care providers by (a) helping providers become and stay enrolled as HCBS Medicaid providers, (b) recruiting home care providers through job advertisements and job fairs, (c) connecting providers to training benefits and opportunities for professional development, (d) helping providers to access health insurance coverage and other benefits and (e) facilitating communication with providers in the event of a public health or other emergency; and

iii. Support state oversight of home care providers by (a) facilitating background checks, (b) verifying provider qualifications and identifying special skills and (c) facilitating communication with providers in the event of a public health or other emergency.

The Act permits the Commissioner of DSS to request increased funding from the Centers for Medicare and Medicaid Services for the development, maintenance and ongoing operations of the registry. DSS may adopt regulations to implement requirements for the registry.

Section 2 of the Act requires each home health care agency, home health aide agency and hospice agency to submit the information required for the home care provider registry to DPH in a form and manner prescribed by DPH, unless the employee asserts an exemption. DPH will provide the information to DSS to include in the home care provider registry.

Section 3 imposes the same requirement for home-maker companion agencies to submit the information required for the home care provider registry to DCP in a form and manner prescribed by DCP, unless the employee asserts an exemption. DCP will, in turn, provide the information to DSS to include in the home care provider registry.

§§ 4 & 5 – Medicare Nursing Home Care Compare Website Link

These Sections require DSS and DPH to post a link to Nursing Home Compare, the Medicare online reporting tool that allows the public to compare nursing homes by quality of care, in a prominent location on their websites.

§ 6 – Expanding Fingerprinting Locations
Effective May 21, 2024

This Section requires the Commissioner of DESPP, in consultation with the Commissioner of DPH, to develop and implement a plan to expand fingerprinting locations in the State to facilitate greater access for individuals requiring state and national criminal history records checks for employment or licensing purposes. By January 1, 2025, the Commissioner of DESPP must report on the plan to expand fingerprinting locations to the General Assembly's Public Safety, Aging and Public Health Committees.

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§§ 7-9 – Home Care Employee Badges and Photographs

Section 7 requires each home health care agency, home health aide agency and hospice agency to mandate agency employees to wear an identification badge with the employee's name and photograph during each appointment with a client. Section 8 requires that each homemaker-companion agency must implement the same requirement beginning July 1, 2025. If it is determined that an agency has failed to comply with these requirements, DPH or, in the case of homemaker-companion agencies, DCP, may initiate disciplinary action against the agency.

Section 9 extends the existing law providing grounds for DCP to revoke, suspend or refuse to issue or renew any certificate of registration as a homemaker-companion agency or place an agency on probation or issue a letter of reprimand, by permitting DCP, beginning July 1, 2025, to impose these disciplinary actions when a homemaker-companion agency fails to require an employee who is scheduled to provide client services to wear a badge. If a homemaker-companion agency is found at an administrative hearing to have violated the requirement to wear a badge three (3) times in one (1) calendar year, the Commissioner of DCP must revoke the homemaker-companion agency's certificate of registration.

§§ 10-13 – Presumptive Medicaid Eligibility for Home Care
Effective July 1, 2024

These Sections require the Commissioner of DSS to create a presumptive Medicaid eligibility system under which the State will fund Connecticut home-care program services for the elderly for a maximum of ninety (90) days for applicants who require a skilled level of nursing care and are presumptively eligible for Medicaid coverage.

The presumptive Medicaid eligibility system must include, but is not limited to:

i. Development by DSS of a preliminary screening tool to be used by representatives of the access agency to determine whether an applicant is functionally able to live at home or in a community setting and is likely to be financially eligible for Medicaid;
ii. A requirement that the applicant complete a Medicaid application no later than ten (10) days after that applicant is preliminarily screened for functional eligibility;
iii. DSS's determination of presumptive eligibility for eligible applicants and initiation of home care services no later than ten (10) days after an applicant is successfully screened for eligibility; and
iv. A written agreement signed by the applicant attesting to the accuracy of financial and other information that the applicant provides and acknowledging that the State will fund services no longer than ninety (90) days after the date on which home care services begin.

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DSS will make a final determination for applicants determined to be presumptively eligible for Medicaid coverage not later than forty-five (45) days after the receipt of a completed Medicaid application, or no later than ninety (90) days after receipt of the application for an applicant with disabilities.

The Commissioner of DSS must seek any federal waiver or amend the Medicaid State plan, if permitted, to attempt to secure federal reimbursement for the cost of providing coverage to persons who are presumptively Medicaid eligible. The provisions of the presumptive eligibility program shall not be effective until DSS obtains federal reimbursement through the waiver or State plan amendment process. The Medicaid eligibility system must run for at least two (2) years before the Commissioner of DSS may, in their discretion, discontinue the system if the system is determined to not be cost effective.

The Act further expands DSS' existing annual reporting requirements to the General Assembly's Human Services Committee to include data on the presumptive Medicaid eligibility system (including the number of persons determined to be presumptively eligible and, of those, the number later determined not to be eligible) as well as comparative data on the estimated savings in providing home care versus institutional care for program participants.

In addition, the Act amends the existing requirement for the Commissioner of DSS to administer a state-funded portion of the Connecticut home-care program for the elderly by clarifying that the program is for those who, among other factors, are not eligible for Medicaid and have income less than or equal to the amount allowed for someone who would be eligible for Medicaid if residing in a nursing facility.

DSS is required to adopt regulations aimed at accomplishing several goals including (a) implementing and administering the Connecticut home-care program and the presumptive Medicaid eligibility system, (b) establishing uniform state-wide standards for the program and uniform assessment tools for use in the screening process for the Connecticut home-care program and the prescreening for presumptive Medicaid eligibility and (c) specifying conditions of eligibility.

§ 17 – Municipal Agents for the Elderly

This Section amends existing law to make the duties of municipal agents for the elderly mandatory, rather than discretionary, as they are presently. This Section also expands the duties of municipal agents to include assisting the elderly with access to community resources to assist elderly persons in gaining access to housing opportunities, including information about access to waitlists for housing designated for the elderly, applications and consumer reports.

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The Commissioner of ADS is directed to create a directory of municipal agents appointed to help seniors learn about community resources and file for benefits. The directory must be created by January 1, 2025 and must include the name, title, phone number, email address and mailing address of each such municipal agent. A link to this directory will be posted on the ADS web site.

§ 18 – Long-Term Care Ombudsman Notification of ALSA Licensure

This Section adds a new requirement that DPH must notify the State Ombudsman within thirty (30) days of granting a license to an ALSA that operates or provides services at an MRC.

§ 19 – MRC Resident Notification

This Section imposes a new requirement for MRCs to provide thirty (30) days' advance notice to residents and their legal representatives before a change of ownership where the business entity operating the MRC changes and before a change in the ALSA providing services at the MRC.

§ 20 – MRC Consumer Guide
Effective May 1, 2024

This Section requires the State Ombudsman, in consultation with DPH, to develop an MRC consumer guide containing the following information: (a) resident protections, (b) housing protections including those related to evictions, (c) MRC fees and (d) any other information the Ombudsman deems relevant. The MRC consumer guide will be posted no later than January 1, 2025 on the websites of the Office of the LTCO and DPH and on the MyPlaceCT website.

§ 21 – Regional LTCO Duties

This Section expands the duties of the regional ombudsman to include carrying out activities related to the Community Ombudsman program.

§ 22 – Office of the LTCO Client Records Disclosure

This Section amends the existing law prohibiting disclosure of any complainant or resident whose files are maintained by the LTCO without the person's consent by clarifying that, if a complainant or resident is not capable of providing written consent to disclosure due to a physical, cognitive or mental health condition or disability, then the complainant or resident may communicate consent orally, visually or through the use of auxiliary aids and services.

§ 23 – Community Ombudsman Program

This Section amends the existing statute related to the Community Ombudsman program to provide the Community Ombudsman with access to data pertaining to medical, social and other data relating to the client's long-term services and supports provided by a home care provider to

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the client, provided that the client consents in writing, or if unable, the client may consent orally, visually, or through the use of auxiliary aid and services.

Furthermore, this Section permits the LTCO to assign a regional community ombudsman the duties and responsibilities of a regional ombudsman for the Office of the LTCO.

§ 24 – Study on Medicaid Family Caregiver Support Benefits
Effective May 1, 2024

This Section requires the Commissioner of DSS to conduct a study on the feasibility of pursuing a family caregiver support benefit through a Medicaid demonstration waiver that would provide respite services and support to individuals who are not otherwise eligible for such services under Medicaid. The study will include an examination of (a) Oregon's project independence and family caregiver assistance program, (b) other options to expand eligibility for respite services for individuals who are not eligible for Medicaid and (c) potential state-funded long-term care services that could be used to offset the costs of a family caregiver support benefit. The Commissioner of DSS must report the results of the study by January 1, 2025 to the General Assembly's Aging and Human Services Committees.

§ 25 – Nursing Home Center of Excellence Program
Effective July 1, 2024

This Section requires the Commissioner of DPH to design a new state-wide Centers of Excellence Program to incentivize nursing homes providing services consistent with the best practices for person-centered care. Each such nursing home will be designated as a "Center of Excellence."

In designing the state-wide Centers of Excellence Program, the Commissioner of DPH must (a) study the extent to which the program may improve the quality of care provided at nursing homes and the best practices in other similar programs nationwide and (b) consult with nursing home owners and operators, hospitals, nursing home residents and their advocates, as well as the LTCO, DSS, OPM and other relevant stakeholders, as deemed necessary by the Commissioner of DPH.

The Act requires that the Centers of Excellence Program must be designed, at a minimum, to do the following:

- Identify evidence-based qualitative and quantitative standards for delivery of person-centered care that a nursing home will need to meet to be designated as a Center of Excellence;
- Identify for each standard the measure(s) nursing homes must meet to qualify as a Center of Excellence;

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- Identify a pathway through which a nursing home may be designated as a Center of Excellence, by either application, inspection or other means;
- Create a mechanism to designate nursing homes that qualify as a Center of Excellence by meeting or exceeding the identified standards;
- Determine ways to incentivize nursing homes that meet the standards set for the Centers of Excellence Program; and
- Identify ways to use available federal funding to support the Program.

The Centers of Excellence Program will be voluntary. Nursing home will not be required to participate in or be penalized for not participating in the program. In addition, DPH may engage a consultant, within available appropriations, to identify best practices and design the Centers of Excellence Program. Once the Centers of Excellence Program is developed, by January 1, 2026, the Commissioner of DPH must report to the Secretary of OPM on the plan.

The Act also allows the Commissioner of DSS to seek approval to amend the State Medicaid plan or a waiver from federal law to incentivize nursing homes for the Centers of Excellence Program.

§ 26 – Online Nursing Home Consumer Dashboard
Effective July 1, 2024

This Section requires that DPH, in consultation with the Office of the LTCO and the Long-Term Care Advisory Council, must establish an online nursing home consumer dashboard that provides comprehensive information concerning quality of nursing home care and showcases leading industry practices. The link to the dashboard must be posted prominently on DPH's website.

III. ACTS AFFECTING HOUSING AND RENT

7. PUBLIC ACT 24-143. AN ACT CONCERNING MUNICIPAL APPROVALS FOR HOUSING DEVELOPMENT, FINES FOR VIOLATIONS OF LOCAL ORDINANCES, REGULATION OF SHORT-TERM RENTALS, RENTAL ASSISTANCE PROGRAM ADMINISTRATION, NOTICES OF RENT INCREASES AND THE HOUSING ENVIRONMENTAL IMPROVEMENT REVOLVING LOAN AND GRANT FUND.
Effective October 1, 2024 for selected sections summarized

§ 3 – Conversions of Nursing Homes to Multifamily Housing

This Section requires that any zoning regulations adopted by a municipality must allow for the conversion of nursing homes (defined to include licensed chronic and convalescent nursing homes and rest homes with nursing supervision) into multifamily housing through a summary review process provided: (a) the nursing home is a freestanding structure, (b) the nursing home is not a

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nonconforming use, (c) the conversion does not result in substantial alteration of the structure's footprint, (d) the conversion does not result in the total demolition and (e) the nursing home has been vacant for at least ninety (90) days prior to the submission of the summary review application, as declared in writing by the owner. Notwithstanding any of the above, a municipality may also require a public hearing, variance, special permit, special exception or other discretionary zoning action if the conversion involves substantial alteration of the structure's footprint or total demolition.

"Summary review" is defined as approval based on zoning regulations without requiring a public hearing, or granting of a variance, special permit, special exception or any other discretionary zoning action, except for determining site plan conformity and ensuring public health and safety will not be substantially impacted. "Dwelling unit" is defined as provided in C.G.S. § 47a-1 to mean any house or building or portion thereof, which is occupied, is designed to be occupied or is rented, leased or hired out to be occupied, as a home or residence of one (1) or more persons. Finally, "multifamily housing" is defined as provided in C.G.S. § 8-13m to mean a building that contains or will contain three (3) or more residential dwelling units.

Lastly, this Section provides that the summary review process for the approval of the conversion requires a decision to be made within sixty-five (65) days of the application's receipt by the planning commission, zoning commission or both. The applicant may also consent to one (1) or more extensions of up to an additional sixty-five (65) days or may withdraw the application.

§ 4 – Surplus State Property as Low- and Moderate-Income Housing

This Section amends the existing law to add the requirement that if the Commissioner of Housing determines the land can be used for construction, rehabilitation, or renovation for low and moderate-income housing, the Commissioner must submit a plan with a budget and timetable for such use. Furthermore, if the Commissioner of Housing submits such plan, the secretary must prioritize this plan and transfer the land to the Commissioner unless such transfer is deemed infeasible in writing.

§ 9 – Assessment of Certain Affordable Housing

This Section amends C.G.S. § 8-216a governing the valuation of affordable housing to add the definition of "net rental income," which is defined as the gross income of any real property used solely for low or moderate-income housing, limited by the schedule of rents or carrying charges, less reasonable operating expenses and property taxes.

§§ 11-12 – Middle Housing Developments

These Sections amend existing laws and impose new requirements related to housing and zoning regulations.

Section 11 expands zoning regulations to permit as-of-right development of any type of middle housing on any lot that allows for residential, commercial or mixed-use development. Middle

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housing is defined as "duplexes, triplexes, quadplexes, cottage clusters and townhouses." This Section also provides that municipalities adopting these zoning regulations will be awarded one-quarter housing unit-equivalent point for each dwelling unit for which a certificate of occupancy has been issued. Municipalities that have (a) adopted zoning regulations that allow for as-of-right development of middle housing, (b) received housing unit-equivalent points and (c) qualified for a moratorium from the affordable housing appeals procedure, must not repeal or substantially modify such regulations during the moratorium period.

Section 12 amends C.G.S. § 8-30g(1)(6) to add the provision that unrestricted units in a set-aside development and dwelling units in middle housing developed as of right pursuant to Section 11, shall be awarded one-quarter point each.

§ 13 – RAP Maximum Rent Levels

This Section amends C.G.S. § 8-345 to add the definition of "housing" or "housing unit" as any house or building or portion thereof, that is occupied, designed to be occupied or rented, leased or hired out to be occupied exclusively as a home or residence of one (1) or more persons.

Furthermore, this Section amends existing law to require the Commissioner of Housing to apply the fair market rent established under the federal Housing Choice Voucher Program, 42 U.S.C. 1437f(o), if it is greater than the maximum allowable rent established by the Commissioner of Housing for a housing unit. Specifically, the fair market rent will apply for such housing units if it exceeds the Commissioner of Housing's established maximum allowable rent.

§ 14 – Tax Increment District Funding for Affordable Housing Renovation

This Section amends C.G.S. § 7-339hh to cover the costs of renovating or rehabilitating set-aside housing developments outside the tax increment district. Such developments must have deed covenants or restrictions expiring within three (3) years and the owner must agree to renew these covenants or restrictions for at least forty (40) years.

§ 15 – RAP Reporting Requirements

This Section amends C.G.S. § 3-37rrr to push the deadline regarding the requirement that the Commissioner of Housing submit a report to General Assembly's Appropriations, Housing, Human Services and Public Health Committees from January 1, 2014, to January 1, 2025 and annually thereafter. This Section further clarifies that the report must detail the number of departmental clients, the number of recipients of rental assistance certificates and data on the utilization of such certificates. Specifically, the report must include the number of applicants remaining on any waitlist for a rental certificate, the number of applicants who received certificates in the prior year, the date of the last opening on any waitlist, the number of applications submitted during the last waitlist opening and the number of applicants added to waitlists in the prior year. The report must also establish targets to ensure rental assistance resources are allocated in accordance with legislative intent.

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§ 17 – Notice of Rent Increases

This new Section applies to any rental agreement entered into, renewed or extended on or after October 1, 2024. It expands the requirements for rental agreements to ensure tenants receive adequate notice before rent increases. Specifically, no rent increase for a dwelling unit can be effective unless the landlord gives the tenant written notice at least forty-five (45) days before the proposed increase is set to take effect. For leases with a term of one (1) month or less, the notice period must be equivalent to the length of the full lease term. A tenant's failure to respond to the notice does not constitute agreement to the proposed increase. Furthermore, *this Section does not (a) allow a landlord to increase the rent during the term of a rental agreement or (b) alter any notice requirements concerning rent increases imposed by federal law. Note that Public Act 24-141 §8 requires that MRCs provide at least 90 days' notice of any increase to monthly or recurring fees. As a result, MRCs should comply with the 90-day notice requirement.*

§ 19 – Municipal Reports to Department of Economic and Community Development on Housing Permitting and Demolition

This Section expands the definition of "low-income resident" to include any other definition included in a state program utilizing federal funding, as determined by the Commissioner of Energy and Environmental Protection. Additionally, this Section amends C.G.S. § 8-240a to change the name of the revolving loan fund known as the "Housing Environmental Improvement Revolving Loan Fund" to "Housing Environmental Improvement Loan and Grant Fund."

IV. SOCIAL WORK AND NURSE LICENSURE COMPACTS

8. PUBLIC ACT 24-30. AN ACT CONCERNING SOCIAL WORKERS.
Effective May 21, 2024

§ 1 – The Social Work Licensure Compact.

This Act enters Connecticut into the Social Work Licensure Compact (the "Social Work Compact"). The Social Work Compact creates a process for social workers to obtain a multistate license from their home state (in this case, Connecticut), allowing them to practice, including the provision of telehealth services, in any state that is a member of the Social Work Compact.

Section 1 sets out the text of the Social Work Compact. To participate in the Social Work Compact, states must license and regulate the practice of social work at the clinical, master's or bachelor's category and establish requirements related to education and supervised practice. They must also have a mechanism in place for receiving, investigating and adjudicating complaints about licensees.

To be eligible for a multistate license an applicant shall: (a) hold or be eligible for an active unencumbered home state license; (b) pay all applicable fees; (c) submit fingerprints or other

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biometric data for a criminal history check; (d) notify the home state of any adverse action, encumbrance or restriction on any professional license by any state no later than thirty (30) days after the date of the action; (e) meet any continuing competency home state requirements; and (f) abide by the laws, regulations and applicable standards in the member state where the client is located at the time care is rendered.

Additionally, to be eligible for a clinical-category multistate license, an applicant must (a) pass a clinical-category qualifying national exam unless the applicant had a clinical category licensure in the applicant's home state before the national exam was required and (b) meet applicable educational and supervised clinical practice requirements.

The Social Work Compact addresses a state's authority to investigate and discipline social workers practicing under its procedures while maintaining the member state's authority to regulate social work consistent with the Social Work Compact. A social worker's services in a remote state are subject to that state's regulatory authority. The Social Work Compact is administered by the Social Work Licensure Compact Commission, which consists of one (1) delegate appointed by each member state's social worker licensing authority. Additionally, each member state must submit specified data on licensees to be included in a database, subject to certain requirements.

It is the responsibility of the member states to report any adverse action against a licensee and to monitor the database to determine whether adverse action has been taken against a licensee. Adverse action information entered by a member state must be available to all other member states. A member state contributing such information may designate information that may not be shared with the public without the express permission of the contributing state and shall remove any information submitted that is subsequently expunged pursuant to federal law or the laws of the member state contributing the information.

§ 2 – Criminal History Check Requirement.

This Section requires that each individual seeking licensure as a social worker must undergo a national fingerprint-based criminal history check in accordance with C.G.S. § 29-17a, which describes the criminal history record check procedure. Fingerprints must be submitted to the State Police Bureau of Identification for a state criminal history check and to the Federal Bureau of Investigations for a national criminal history check.

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9. PUBLIC ACT 24-83. AN ACT ADOPTING THE NURSE LICENSURE COMPACT.
Effective May 30, 2024

§ 1 – Nurse Licensure Compact

This Act enters Connecticut into the Nurse Licensure Compact ("Nurse Compact") from October 1, 2025 until January 1, 2028. The Nurse Compact creates a process for nurses, including RNs, LPNs, or VNs to obtain a multistate license from their home state of licensure (in this case, Connecticut) allowing them to practice in any state that is a member of the nurse Compact including by telehealth.

Section 1 sets out the text of the Nurse Compact. To participate in the Nurse Compact, states must consider applicants' criminal history records and require submission of fingerprints or other biometric-based information to obtain such records from the Federal Bureau of Investigation and the state agency responsible for retaining state criminal records.

To be eligible for a multistate license, an applicant must satisfy the following criteria: the applicant must (a) meet Connecticut's qualifications for nurse licensure or renewal and all other applicable State laws; (b) have graduated from or be eligible to graduate from an acceptable prelicensure education program and successfully passed qualifying exams; (c) if the applicant graduated from a foreign prelicensure education program, the applicant must pass an English proficiency examination if English is not their native language; (d) successfully pass a National Council Licensure Examination for Registered Nurses or a National Council Licensure Examination for Practical Nurses administered by the National Council of the State Boards of Nursing, or a nationally recognized predecessor to said examinations, as applicable; (e) be eligible for or hold an active, unencumbered license; (f) submit fingerprints or other biometric-based information to obtain federal and state criminal records; (g) have no prior conviction, finding of guilt, or plea for a felony or for a misdemeanor offense related to the practice of nursing, as determined on a case-by-case basis; (h) not be enrolled in an alternative multistate licensure program and must self-disclose any such involvement and (i) possess a valid Social Security number (collectively, the "Multistate License Requirements").

Applications for Licensure in a Member State

Member states are required to confirm certain information about each applicant for a multistate license through the coordinated licensure information system, including whether the applicant (a) holds or has ever held a license in another state, (b) has any encumbrances on any license or multistate license privilege, (c) has a history of adverse action against any license or multistate licensure privilege and (d) currently participates in an alternative program.

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A nurse may hold a multistate license issued by the home state in one (1) member state at a time. A nurse who wishes to change the primary state of residence by moving between two (2) member states must apply for licensure in the new home state and the multistate license issued by the prior home state would be deactivated. An application for licensure in the new primary state of residence may be filed prior to the change in primary residence, but the multistate license may not be issued by the new home state until the nurse provides sufficient proof of change in primary state of residence to the new home state and satisfies all licensure requirements of the new home state. Where a nurse moves the primary state of residence to a non-member state, the previously-issued multistate license will convert to a single-state license only valid in the former home state.

Nurses who are residents of nonmember states are permitted to apply for single-state licenses in a member state under that member state's requirements for nurse licensure, but a single-state license does not allow a nurse to practice in other member states. Nurses who already possess a home state multistate license as of May 30, 2024, the effective date of the Nurse Compact (the "Effective Date"), may retain and renew the multistate license issued by the then current-home state, with the following exceptions: (a) a nurse who changes the primary state of residence after the Effective Date must meet the Multistate License Requirements to obtain a multistate license from a new home state and (b) a nurse who fails to satisfy the Multistate License Requirements due to a disqualifying event that occurred after the Effective Date would be ineligible to retain or renew a multistate license and the multistate license will be revoked or deactivated.

Adverse Actions and Compliance

States are authorized to take adverse action against a nurse's multistate licensure privilege including, but not limited to, revocation, suspension, probation and cease and desist. If such adverse action is taken, states must promptly notify the administrator of the coordinated licensure information system, who is required to notify the home state of any such actions taken by a remote state.

Nurses must comply with the practice laws of the state in which the client is located at the time services are provided. The state practice laws govern the practice of nursing, which includes all nursing practice, as defined in the practice laws of the state in which the client is located. Nurses practicing under a multistate license are subject to the jurisdiction of the licensing board, the courts and the laws of the state in which the client is located at the time service is provided.

Coordinated Licensure Information System and Exchange of Information

Member states are required to participate in a coordinated licensure information system that includes licensure and disciplinary information for all licensed RNs and LPNs or VNs, as reported by member states. The Nurse Compact is administered by the Interstate Commission of Nurse

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Licensure Compact Administrators with one (1) voting administer designated for each member state. Any adverse action taken against a nurse's multistate licensure must be promptly reported to the administrator of the coordinated licensure information system.

§ 2 -- Fingerprints

The Nurse Compact requires any individual applying for a multistate nursing license from October 1, 2025 until January 1, 2028 to submit to a state and national fingerprint-based criminal history records check.

§ 3 – Authority to Convert Multistate License to a Single State License

States are permitted, upon request, to convert a multistate license to a single-state license only valid in the home state.

§ 4 -- Professional Assistance Program

This Section requires that from October 1, 2025 until January 1, 2028, the Commissioner of DPH must transfer an additional two dollars ($2) from each RN or LPN license renewed to the professional assistance program account.

§ 5 – Working Group

This Section requires the Secretary of OPM to convene a working group in partnership with the Commissioner of Public Health and a representative of the professional assistance program for regular professions to evaluate the Nurse Compact's implementation. The working group must assess whether the State's continued participation in the Nurse Compact is in the best interest of the health, safety, and welfare of its citizens and to evaluate whether to remain a member of the Nurse Compact. The working group is required to report its findings to the General Assembly's Public Health Committee.

V. ACTS AFFECTING EMPLOYEES

10. PUBLIC ACT 24-8. AN ACT EXPANDING PAID SICK DAYS IN THE STATE
Effective January 1, 2025, except as otherwise noted

This Act makes major revisions to Connecticut's mandatory paid sick leave statute by expanding the requirements to nearly all private employers in the State over the next three (3) years. In addition, the Act changes the rate at which sick leave can accrue, expands the qualifying reasons

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for paid sick leave and expands employer notice requirements, among other revisions. Following is a brief summary of the Act's provisions.

§ 1 – Definitions – Expansion of Employees Covered Under the Law

This Section makes certain changes to revise existing definitions, while removing and adding some defined terms. Relevant definitions are referenced, as applicable, in the sections below.

§ 2 – Phase-In Schedule, Paid Sick Leave Accrual and Compensation

The Act broadens the scope of employees who are eligible for paid sick leave. Current law only requires paid sick leave for "service workers," thus limiting coverage to individuals in retail and service jobs, including health care services. The Act redefines the term "employee" to include all private sector employees with the exception of seasonal employees and certain unionized construction workers. In addition, current law only applies to an employer with fifty (50) or more employees. However, this Section provides a three (3) year phase-in for compliance with the following deadlines:

- January 1, 2025: employers with twenty-five (25) or more employees in the State;
- January 1, 2026: employers with eleven (11) or more employees in the State; and
- January 1, 2027: employers with one (1) or more individuals employed in the State.

Several other changes take effect January 1, 2025:

- Paid sick leave will accrue beginning on the employee's first date of employment at a rate of one (1) hour of paid sick leave for each thirty (30) hours worked (current law requires one (1) hour for each forty (40) hours worked) up to a maximum of forty (40) hours per year. Employers have the option to provide employees with a greater amount of paid sick leave or provide with a faster rate of accrual if so desired.
- Instead of allowing for carry-overs of unused paid sick leave from one (1) year to the following year, employers may instead provide employees with such amounts of paid sick leave for immediate use at the beginning of the following year.
- As to the entitlement to paid sick leave, this Section reduces the requirement that the individual have completed 680 hours of employment with an average of ten (10) or more hours per week, to instead require that the employee have worked 120 calendar days.
- Employees exempt from overtime will be presumed to work forty (40) hours per week for purposes of paid sick leave accrual unless such employee works less than forty (40) hours during a normal week.
- If an employee is transferred internally while working for an employer from one division, entity or worksite to another, such employee shall retain and use the same paid sick leave. Similarly, if an employer replaces an existing employer, remaining employees of the original employer shall retain and use the same paid sick leave.

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- Employers may not require employees who will use their paid sick leave to search for or find another employee to serve as their replacement during the hours that such employee is scheduled to work.

§ 3 – Expanded Reasons for Paid Sick Leave

This Section clarifies that, in addition to using paid sick leave for illness, injury or health condition, an employee may use paid sick leave for preventative medical care, which includes both mental and physical health or for the employee's own mental health wellness day. Paid sick leave may also be used for closures by order of a public official due to a public health emergency, when there has been exposure by the employee or family member to a communicable disease and where an employee or family member is a victim of family violence or sexual assault. Importantly, this Section provides the ability to take leave not only to care for one's child or spouse, but to care for any family member's mental or physical health. "Family member" is defined as a spouse, sibling, child, grandparent, grandchild or parent of an employee. The term may also include an individual related to the employee by blood or affinity whose close association to that employee seems equivalent to those family relationships.

Finally, this Section removes the current provision permitting employers to require documented notice of sick leave to now prohibit an employer from requiring that the employee provide documentation of the purpose for which paid sick leave is taken.

§ 4 – Employer Protocol for Sick Leave Policy and Employee Rehiring

This Section clarifies that terms of any collective bargaining agreement entered into on or after July 1, 2012 will not be preempted or overridden because of the Act's amendments to sections regarding sick leave.

§ 5 – Prohibited Actions for Employers Regarding Paid Sick Leave

This Section as amended only provides for conforming changes.

§ 6 – Communication Guidelines for Employers Regarding Paid Sick Leave and Maintaining Records

This Section adds the requirement that, in addition to displaying posters conveying relevant information about paid sick leave, employers must provide written notice to each employee by January 1, 2025 or at the time of hire, whichever is later. As under current law, the notice must inform the employee of (a) the entitlement to paid sick leave; (b) the amount of paid sick leave provided; and (c) the terms under which paid sick leave may be used. The notice must also state

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that retaliation against an employee for requesting or using paid sick leave for which the employee is eligible is prohibited and the employee has a right to file a complaint with the Labor Commissioner for any violation of the paid sick leave law. It clarifies that the Labor Commissioner will create a model for the poster and written notice and will make the model available to all employers on the Labor Department's web site. Further, it provides that if an employer does not maintain a physical workplace or has employees who work remotely, in order to comply with displaying a poster, an employer must send the information via electronic communication or by posting it on their web-based or application-based platform.

In addition, this Section clarifies that employers who comply with providing sick leave will also need to add to employee pay stubs or other wage records at the time of wage payments the following information: (a) the number of hours, if any, of paid sick leave accrued by or provided to the employee and (b) the number of hours, if any, of paid sick leave used by the employee during the calendar year. These records must be maintained for a period of three (3) years and accessible to the Labor Commissioner to monitor compliance when so requested. Failure to comply with these requirements can result in a civil penalty of up to one hundred dollars ($100).

Lastly, a catch-all provision is provided to allow the Labor Commissioner to adopt certain regulations to implement the provisions of this Section and sections regarding employer requirements for sick leave, permitted use of sick leave, additional leave and prohibited retaliatory action, as amended by this Act.

11. PUBLIC ACT 24-5. AN ACT CONCERNING CHANGES TO THE PAID FAMILY AND MEDICAL LEAVE STATUTES.
Effective October 1, 2024, except as otherwise noted

This Act makes various changes in the State's paid family and medical leave act ("PFMLA), Family and Medical Leave Act ("CTFMLA") and family violence leave law. The State's Paid Family Medical Leave Program is an employee-funded program providing up to twelve (12) weeks of partial wage replacement benefits to employees on unpaid leave from employment under the CTFMLA (for example, due to a serious health condition or for the birth of a child) or under the family violence leave law (for example, to obtain victim services or relocate).

Following is a summary of relevant revisions:

§ 2 – Employer Penalties and Compensation for Covered Employees

This Section amends existing law and expands the oversight of the Paid Family and Medical Leave Insurance Authority (the "Authority") over employers. Each employer that pays wages to an employee must register with the Authority and submit reports required by the Authority. In addition, employers who fail to comply with requirements related to paid family and medical leave will be subject to certain penalties established by the Authority. This Section also provides that a covered employee may be compensated concurrently by the PFMLA and the victim compensation

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program administered by the Judicial Department's Office of Victim Services, provided that the total compensation during the covered employee's period of leave does not exceed the covered employee's regular rate of compensation.

§ 3 – Informational Posters for Practitioners

This Section amends existing law by requiring health care providers to display an informational poster that must be developed by the Authority by October 1, 2024. The poster must be displayed in a clear and conspicuous manner accessible to patients and caregivers. The term "health care provider" includes individual practitioners such as a doctor of medicine or osteopathy, podiatrist, dentist, psychologist, optometrists, chiropractor, APRN, nurse practitioner, nurse midwife and clinical social worker, among others.

§ 4 – Overpayments

This Section amends the existing law related to false claims to obtain family and medical leave compensation and erroneous payments. Specifically, any person who has received an overpayment of benefits must repay the excess amount according to a payment schedule determined by the Authority. Similarly, any person who has been assessed a penalty by the Authority must pay the penalty according to a payment schedule determined by the Authority. Failure to pay the overpayment or the penalty in accordance with the payment schedule will result in a 1% interest rate on the amount owned each month, and the Authority may request the Commissioner of Administrative Services to seek reimbursement for the amount owed plus interest.

§ 5 – Annual Reporting
Effective May 9, 2024

This Section amends the Authority's existing deadline to report to the Office of Policy Management and to the General Assembly's Appropriations and Labor Committees from July 1, 2022 to September 1, 2024.

§ 8 –Family Medical Leave Provisions for Victims of Sexual Assault

This Section expands the current requirement that employers must provide paid or unpaid leave where the employee is a victim of family violence to now require that employers also provide such leave to employees who are victims of sexual assault. Finally, employers may request a record related to the sexual assault when that is the basis for the employee's request for leave.

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VI. ACTS AFFECTING ACCESSIBILITY

12. PUBLIC ACT 24-113. AN ACT CONCERNING HEALTH CARE ACCESSIBILITY FOR PERSONS WITH A DISABILITY.
Effective July 1, 2024

§ 1 – Patient Accessibility to Health Care Facilities and Practice Locations

This Section amends the law enacted in 2022 related to the accessibility of medical diagnostic equipment in health care facilities. The Act includes certain newly defined terms, summarized below:

- "Commercially reasonable price" is defined as "a price that does not exceed the fair market value of medical diagnostic equipment that meets the standards for accessibility."
- "Practice location" is defined as the office of a practice of nine or more licensed physicians or APRNs, or a combination thereof.
- "Standards for accessibility" is defined as the technical standards for accessibility developed for medical diagnostic equipment by the federal Architectural and Transportation Barriers Compliance Board in accordance with the Affordable Care Act.

The existing requirement that health care facilities (defined as a hospital, outpatient clinic, long term care facility and hospice facility) take into consideration the standards for accessibility was broadened to also impose the requirement on practice locations, as defined above, and to remove the limitation that the requirement only apply when purchasing medical diagnostic equipment. As amended, health care facilities and practice locations must take the standards for accessibility into consideration at all times.

The Commissioner of DPH must now provide annual notice regarding the standards for accessibility to practice locations in addition to health care facilities. Individual practitioners are no longer required to receive such notice.

The Act adds a new requirement that by January 1, 2025, each health care facility and practice location must take the following actions:

- Train staff with direct patient care responsibilities regarding its policies and procedures for addressing patients' access to care;
- Designate a contact phone number and provide the steps patients may take to contact the health care facility or practice location for assistance with access needs. The health care facility or practice location must post this information on their website or otherwise make the information readily available to the public; and
- Take an inventory of all medical diagnostic equipment that meets the standards for accessibility and all medical diagnostic equipment that does not meet such standards and

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create an action plan for addressing gaps in the inventory. This documentation must be made available to DPH upon request.

Beginning January 1, 2026 and until federal regulations addressing accessibility of medical equipment become mandatory, each health care facility or practice location with three (3) or more examination rooms must:

- When purchasing, leasing, replacing or otherwise obtaining medical diagnostic equipment, independently verify or obtain assurances from the seller or source that the equipment complies with the standards for accessibility. Documentation must be maintained of such verification or assurances.
- Have an examination table or examination chair available that meets the standards for accessibility in at least one (1) examination room that is capable of allowing a patient to use an assistive device such as a wheelchair to easily enter, exit and maneuver in the room.
- If the health care facility or practice location uses a weight scale, it must have at least one (1) weight scale available that meets the standards for accessibility.

A health care facility or practice location is exempt from the three (3) requirements set forth above if it:

- Is unable to comply because the facility or location is unable to obtain medical diagnostic equipment that is commercially available at a commercially reasonable price;
- Is delayed in compliance because it is in the process of obtaining a necessary approval from a municipal or state agency, including approval related to the building code, a building inspection, a site plan review or certificate of need; and
- Meets the criteria to be exempt from a requirement set forth in a federal law protecting persons with disabilities, including the Americans with Disabilities Act or Section 504 of the Rehabilitation Act that is the same or substantially similar to the requirements set forth above.

§ 2 – Guidelines for Compliance Acceptance

This Section requires that DPH accept facility plans for construction or building alterations in certain circumstances. Under this Section, except as permitted under current state and federal law, when DPH reviews a health care facility's plan for a project for construction or building alteration that is necessary to comply with the medical equipment accessibility requirement set forth in statute (as amended by this Act), DPH must accept compliance with the nationally established facility guidelines for health care construction that are either in place at the time the facility provides the plan to DPH or are the most recent prior version of such guidelines. DPH is required to adopt regulations to implement provisions of this Section.

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13. PUBLIC ACT 24-58. AN ACT CONCERNING WHEELCHAIR REPAIR REQUIREMENTS
Effective July 1, 2024

This Act implements new requirements for wheelchair repair authorized dealers and prohibits Medicaid and private individual and group insurers from requiring prior authorizations and prescription requirements for medically necessary customized wheel chair repairs unless the original prescription is more than five (5) years old.

§ 1 – Definitions

The Act provides for certain new defined terms. The following is a summary of the defined terms used in the Act:

- "Authorized wheelchair dealer" is defined as "any company doing business in the state selling or leasing wheelchairs, including complex rehabilitation technology wheelchairs."
- "Complex rehabilitation technology" has the same meaning provided in existing law and means "products classified as durable medical equipment within the Medicare program as of January 1, 2013, that are individually configured and medically necessary for individuals to meet their specific and unique medical, physical and functional needs and capacities for basic and instrumental activities of daily living," including (a) complex rehabilitation manual and power wheelchairs and accessories, (b) adaptive seating and positioning items and accessories and (c) other specialized equipment and accessories such as standing frames and gait trainers.
- "Complex rehabilitation technology wheelchair" is defined as "a specialized, medically necessary manual or powered wheelchair individually configured for the user with specialized equipment that requires evaluation, configuration, fitting, adjustment, programming, and long-term maintenance and repair services."
- "Consumer" is defined as "the purchaser or lessee of a wheelchair, including a complex rehabilitation technology wheelchair, irrespective of whether the purchase or lease of the wheelchair is funded in whole or in part by the consumer or privately or publicly funded health insurance."
- "Timely repair" is defined to mean "as soon as practicable but not later than ten business days after the date of the request for repair from a consumer, provided (a) the consumer makes the wheelchair available, (b) any prior authorization required from an insurer has been acquired, and (c) any time spent waiting for prior authorization from an insurer or for delivery of necessary parts ordered for the repair by an authorized wheelchair dealer shall not be included in the ten business days."
- "Wheelchair" is defined as "a manual or motorized wheeled device that enhances the mobility or positioning of an individual with a disability and includes a complex rehabilitation technology wheelchair."

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§ 2 – Timely Repair and Reporting Requirements for Authorized Wheelchair Dealers

This Section imposes new requirements on authorized wheelchair dealers to make timely repairs to wheelchairs, including CRT wheelchairs, that the dealer has sold or leased in Connecticut. An authorized wheelchair dealer who sells or leases a CRT wheelchair in the State is required to provide timely repair of such wheelchair at a consumer's home upon request.

In addition, the authorized wheelchair dealer must maintain an e-mail address and a phone line for consumer repair requests that are accessible each business day and capable of receiving and recording messages. The dealer is required to respond to a request for wheelchair repair within one (1) business day after the date of the request and to order parts for a repair within three (3) business days after the dealer has assessed the need for repair or received prior authorization from an insurer for the repair.

Beginning July 1, 2024, OHA will be required to maintain a phone number and e-mail address that are posted conspicuously on the DCP and OHA's websites and to receive and record complaints regarding timely repair issues. No later than January 1, 2025, and annually thereafter, the Healthcare Advocate will submit a report of these complaints to the General Assembly's General Law, Human Services and Insurance Committees.

By December 31, 2024, and annually thereafter, authorized wheelchair dealers that contract with DSS to sell or lease wheelchairs to Medicaid beneficiaries must submit a report to the Commissioner of DSS and the complex rehabilitation technology and wheelchair repair advisory

council that is required to be established in Section 4, below. The report will include the minimum, maximum and average times from the date and time of a repair request for the authorized wheelchair dealer to:

- Respond;
- Conduct a repair assessment (a) in the home or other community location, (b) remotely, or (c) at a repair facility;
- Request any necessary prior authorization from DSS and receive a decision from DSS on such request;
- Order any necessary wheelchair parts;
- Receive delivery of needed repair parts; and
- Complete repairs (a) in the home or other community location, (b) remotely, or (c) at a repair facility.

§ 3 – Medicaid Coverage of Customized Wheelchairs

This Section amends existing law to add additional definitions and to limit the requirement for a prescription or prior authorization for certain customized wheelchair repairs. Specifically, this

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Section incorporates the definitions of "authorized wheelchair dealer," "complex rehabilitation technology wheelchair" and "timely repair" from Section 1 of this Act and includes the following additional definitions:

- "Customized wheelchair" is defined as "a wheelchair built, designed or outfitted for a Medicaid recipient with a physical disability unable to achieve maximum mobility with a standard wheelchair and includes a complex rehabilitation technology wheelchair."
- "Medically necessary" has the same meaning as provided in existing Medicaid statutes.

This Section further amends the existing law, which requires that that customized wheelchairs are covered under Medicaid only when DSS determines that a standard wheelchair does not meet the individual's needs, to add that the customized wheelchairs must also be "medically necessary", as defined above, in order to be covered by Medicaid.

Additionally, beginning July 1, 2024, DSS must no longer require a new prescription or prior authorization for the medically necessary repair of a customized wheelchair unless the original prescription for the wheelchair is more than five (5) years old.

The Commissioner of DSS may seek any federal approval necessary to implement the provisions of this section, including amending the Medicaid State plan or applying for a Medicaid waiver.

§ 4 – Establishment of a Complex Rehabilitation Technology and Wheelchair Repair Advisory Council

This Section requires the establishment of a complex rehabilitation technology and wheelchair repair advisory council to monitor repairs of wheelchairs, including complex rehabilitation technology wheelchairs, as defined above, and to make recommendations about improving repair times. The advisory council must include consumers who use a complex rehabilitation technology wheelchair acquired under the Medicaid program, under a private health insurance policy, or pay privately for a CRT wheelchair, as well as advocates for persons with disabilities and representatives of organizations that represent persons with physical disabilities, as well as an authorized wheelchair dealer. The advisory council must also include the Commissioners of the Aging and Disability Services and Insurance Departments, the Commissioner of DSS, the Healthcare Advocate and the Commissioner of DCP, or their designees. Initial appointments to the advisory council must be made by August 1, 2024.

Beginning January 1, 2025, and annually thereafter, the advisory council must submit a report on its findings and recommendations to the General Assembly's Aging, General Law, Human Services and Insurance Committees.

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§ 5-6 –Individual and Group Health Insurance Policies May Not Require A New Prescription or Prior Authorization For Certain Medically Necessary Wheelchair Repairs

These Sections incorporate the definition of "complex rehabilitation technology wheelchair" from Section 1 of this Act and define "medically necessary" as "a written determination by a policy holder's health care provider that repair or replacement of a complex rehabilitation technology wheelchair is necessary to preserve the health of such policy holder."

These Sections require that individual and group health insurance policies delivered, issued for delivery, renewed, amended or continued in Connecticut on and after January 1, 2025, may not require a new prescription or prior authorization for the medically necessary repair or replacement of a CRT wheelchair unless the original prescription is more than five (5) years old.

14. PUBLIC ACT 24-81. AN ACT CONCERNING ALLOCATIONS OF FEDERAL AMERICAN RESCUE PLAN ACT FUNDS AND PROVISIONS RELATED TO GENERAL GOVERNMENT, HUMAN SERVICES, EDUCATION AND THE BIENNIUM ENDING JUNE 30, 2025
Effective May 30, 2024, except as otherwise noted

§ 65 — Bureau of Services for Persons Who Are Deaf, Deafblind or Hard of Hearing
Effective July 1, 2024

This Section establishes a Bureau of Services for Persons who Are Deaf, Deafblind or Hard of Hearing (the "Bureau") within ADS. The Commissioner of ADS must consult with the Advisory Board for Persons Who are Deaf, Deafblind or Hard of Hearing (the "Advisory Board") to hire a Bureau director by October 1, 2024. Such hired director must have professional experience in serving the needs of deaf, deafblind or hard of hearing persons, be able to communicate in American Sign Language and be familiar with effective interpretation methods to assist deafblind persons. In addition, the Commissioner of ADS must hire an administrative assistant for such director.

The director will report to the Commissioner of ADS and will be responsible for the following tasks:

- Assisting in overseeing ADS employees who assist deaf, deafblind or hard of hearing persons, except federally funded rehabilitation employees;
- Annually updating and publishing a resource guide for deaf, deafblind or hard of haring persons on the department's web site;
- Assisting in the registration of state-registered interpreters;
- Assisting state agencies in appointing an employee to serve as a point of contact for concerns related to persons who are deaf, deafblind or hard of hearing and coordinating efforts to resolve any concerns;

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- Coordinating efforts of ADS to provide information to deaf, deafblind or hard of hearing persons on available resources;
- Establishing a Bureau web page that publishes (1) Advisory Board's meetings' schedules, agendas, minutes and other resources, (2) an instructional video for deaf, deafblind or hard of hearing persons on navigating the web page and (3) other materials pursuant to this Section;
- Coordinating responses to consumers and state agencies;
- Coordinating education and training initiatives with (1) public safety and public health officials and (2) interpreters;
- Collaborating with interpreting services and training organizations to increase training opportunities in interpreting services;
- Partnering with civic and community organizations serving deaf, deafblind or hard of hearing persons on workshops and information sessions;
- Raising public awareness of programs and services available to deaf, deafblind or hard of hearing persons;
- Assisting the Public Utilities Regulatory Authority in implementing telecommunication relay service programs for deaf, deafblind or hard of hearing persons;
- Working with the Governor and state television stations to increase the accessibility of broadcasts for deaf, deafblind or hard of hearing persons and
- Consulting with the Advisory Board to address policy changes to better serve deaf, deafblind or hard of hearing persons.

§ 66 — Advisory Board Responsibilities
Effective October 1, 2024

This Section renames the advisory board from "the Advisory Board for Persons who are Deaf, Hard of Hearing or Deafblind" to "The Advisory Board for Persons Who are Deaf, Deafblind or Hard of Hearing" and makes conforming statutory changes. The Advisory Board's goals have been expanded to include making recommendations to rectify gaps in services for persons who are deaf, deafblind, or hard of hearing.

This Section further establishes that by January 1, 2025, the Advisory Board must report to the Governor and the General Assembly's Committees with the Advisory Board's recommendations and a report on the Bureau's activities in the previous calendar year. Lastly, this Section expands the list of the General Assembly's Committees receiving the report to include the Appropriations, Aging, Commerce, Education, Higher Education, Housing, the Judiciary, Labor, Public Health and Public Safety Committees.

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§ 67 — Advisory Board Membership
Effective October 1, 2024

This Section amends the existing law regarding the Advisory Board's membership, to remove the Commissioner of ADS or the Commissioner's designee, and replace him or her with the President of Hear Here Hartford, the President of the Connecticut chapter of the Hearing Loss Association of America (or the President's designee) and to remove the director of the Connecticut Chapter of We the Deaf People and replace him or her with a representative of an organization representing Connecticut hospitals, appointed by the speaker of the House of Representatives.

In addition, this Section provides that, beginning October 1, 2024, the director of the Bureau must serve as administrator of the Advisory Board. Finally, this Section expands the individuals who can fill vacancies on the Advisory Board, from only the Governor, to include, in the alternative, a designated appointing authority.

§ 68 — Point of Contacts at State Agencies
Effective October 1, 2024

This Section requires each state agency, as defined in existing law at C.G.S. § 1-79, to appoint an employee to serve as a point of contact for concerns related to deaf, deafblind or hard of hearing persons. The appointed employee must collaborate with the director of the Bureau to resolve any concerns raised. The appointed employee's name and contact information must be clearly identifiable on the agency's web site.

§§ 69-71 — Committee to Advise Americans with Disabilities Act Coordinator
Effective October 1, 2024

These Sections rename the Advisory Board to include the word "Deafblind" and make conforming changes to include deafblind persons.

§ 72 — Interpreter Services for Deaf, Deafblind or Hard of Hearing Persons
Effective October 1, 2024

This Section amends existing law to include deafblind and hard of hearing persons in the group of individuals to whom ADS may provide necessary services, including, but not limited to, provision of interpreter services and message relay services.

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VII. MISCELLANEOUS PUBLIC ACTS

A. HOME AND COMMUNITY BASED SERVICES TO COMBAT HOMELESSNESS

15. SPECIAL ACT 24-5. AN ACT CONCERNING HOMELESSNESS.
Effective July 1, 2024

This Act implements certain improvements for CHESS, an HCBS program established to improve housing stability and health outcomes for CHESS program participants.

The Act directs the Commissioner of DSS to work alongside the Commissioners of Housing and DMHAS to develop a strategic plan to improve outcomes for participants in the CHESS program and to reduce housing instability state-wide. The strategic plan must include, but not be limited to: (a) amendments to the State plan or HCBS waiver programs necessary to achieve strategic plan goals, (b) establishing more efficient administrative protocols across multiple agencies to ensure timely receipt of benefits to individuals experiencing or at risk of experiencing homelessness and (c) exploring and applying for federal approval of additional Medicaid State plan amendments to target various "social determinants of health", defined as "the conditions in which people are born, work and age".

By January 1, 2025, the Commissioner of DSS and the Commissioners of Housing and Mental Health and Addiction services must file a report with the General Assembly's Aging, Children, Housing, Human Services and Public Health Committees. The report must include but need not be limited to: (a) data metrics of participants in the CHESS programs, (b) plans and progress made related to streamlining multiagency administrative procedures in the CHESS program, (c) sources of additional Medicaid waiver programs or State plan amendments to address social determinants of health and (d) a timeline for applying for the identified Medicaid waiver programs or State plan amendments.

B. MEDICAID ELIGIBILITY

16. SPECIAL ACT 24-4. AN ACT CONCERNING THE EFFICIENCY OF THE DEPARTMENT OF SOCIAL SERVICES IN DETERMINING ELIGIBILITY FOR MEDICAL ASSISTANCE AND RESPONDING TO REQUESTS FOR INFORMATION OR ASSISTANCE.
Effective May 30, 2024

This Act requires the Commissioner of DSS to study the efficiency of DSS in (a) making eligibility determinations for medical assistance, state supplement, temporary assistance to families and the supplemental nutrition assistance program ("State Aid") and (b) responding to requests for information or assistance made by telephone.

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By October 1, 2024, the Commissioner of DSS must file a report with the General Assembly's Joint Committee on Human Services providing the following information:

- The percentage of State Aid eligibility determinations made within the time periods prescribed by statute. Note, that existing law requires that an investigation in response to an application be completed within forty-five (45) days after receipt of the application or within sixty (60) days after receipt of an application that requires a disability determination);
- The average wait time for a person calling DSS for information or assistance; and
- Recommendations to improve DSS' efficiency in making eligibility determinations and responding to requests for information or assistance.

The Commissioner of DSS must also submit reports with this data to the Council on Medical Assistance Program Oversight at least quarterly until July 1, 2026.

C. HOSPITAL EMERGENCY DEPARTMENT CROWDING

17. PUBLIC ACT 24-4. AN ACT CONCERNING EMERGENCY DEPARTMENT CROWDING.
Effective May 4, 2024

This Act imposes new requirements on hospitals to analyze data concerning their emergency departments. By January 1, 2025, and annually thereafter until January 1, 2029, hospitals with an emergency department shall, and hospitals operated exclusively by the State may, directly or in consultation with the hospital association, analyze the following data from the previous calendar year related to their emergency departments: (a) the number of patients who received treatment in the emergency department; (b) the number of emergency department patients admitted to the hospital; (c) the average length of time between a patient's presentation to the emergency department and his or her admission to the hospital and (d) the percentage of patients admitted to the hospital after presenting to the emergency department before being transferred to an available bed at a different location more than four (4) hours after an admitting order was completed. The relevant hospitals must use this analysis to (a) develop policies or procedures to reduce admission wait times, (b) improve admission efficiencies and (c) examine the root causes of delays in admission times.

This Act also requires that by March 1, 2025, and annually thereafter until March 1, 2029, every hospital that conducts this analysis must submit a report to the General Assembly's Public Health Committee regarding its findings and recommendations.

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D. MEDICAL DEBT REPORTING

18. PUBLIC ACT 24-6. AN ACT CONCERNING THE REPORTING OF MEDICAL DEBT.
Effective July 1, 2024

This Act prohibits health care providers and collection agencies doing business in Connecticut from reporting any portion of a medical debt to a credit reporting agency. “Health care provider” is broadly defined to include any person or entity that provides health care or professional services, or an officer, employee or agent of a health care provider acting in scope of his or her employment. "Health care services” is also broadly defined as those services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease. As a result, this Act does apply to health care providers of services to the elderly. Finally, “medical debt" is defined as a consumer’s actual or alleged obligation to pay any amount related to their receipt of health care goods or health care services, not including debt charged to a credit card unless the credit card is issued under an open-end or closed-end credit plan offered specifically for the payment of charges related to health care goods or services.

§ 1 – Prohibition on Reporting Medical Debt

Section 1 contains the provision prohibiting health care providers and collection agencies doing business in Connecticut from reporting medical debt to credit rating agencies for use in credit reports. Contracts entered into by and between health care providers in the State and collection entities for the purchase or collection of medical debt must include an explicit provision to prohibit such reporting. In addition, this Section voids any fraction of a medical debt that is reported to a credit rating agency.

§ 2 – Prohibited Actions for Hospitals, Entities Affiliated with Hospitals and Their Collection Agencies

This Section amends certain time limitations in existing law addressing credit agency reports and collection practices against patients by hospitals, entities affiliated with hospitals and their collection agencies. Based on these amendments, hospitals and entities that are owned or affiliated with such hospitals and collection agencies that receive referrals from such entities shall not:

- On and after July 1, 2024, report a patient to a credit rating agency;
- On or after October 1, 2022, initiate an action to foreclose a lien on a patient’s primary resident if such lien was filed to secure health care payments; or
- On or after October 1, 2022, apply to a court for an execution against a patient’s wages or seek to garnish such patient’s wages to secure health care payments if the patient is eligible for the hospital bed fund.

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E. BOND PACKAGE

19. PUBLIC ACT 24-151. AN ACT AUTHORIZING AND ADJUSTING BONDS OF THE STATE AND CONCERNING PROVISIONS RELATED TO STATE AND MUNICIPAL TAX ADMINISTRATION, GENERAL GOVERNMENT AND SCHOOL BUILDING PROJECTS.
Effective June 6, 2024

This lengthy Act authorizes the State Bond Commission to issue bonds in one (1) or more series for certain express purposes and in specific amounts, including the following that could be of relevance to providers of services for the elderly:

- Authorizes ADS to provide grants-in-aid for aging in place not to exceed $1 million (Section 9).
- Amends existing statute authorizing up to $50,000 for non-profit organizations to improve security infrastructure to provide that receipt of this state funding will not preclude the non-profit organization from applying for additional federal funding provided that the organization does not receive state and federal funding for the same project (Section 28).
- Requires the next adopted version of the State's Building Code and the Fire Safety Code to include amendments that (a) allow additional residential homes to be served by a single exit stairway and (b) encourage construction of safe three- and four-unit residential buildings under similar requirements for certain one (1) and two (2)-unit residential buildings. It also requires the State Building Inspector, the Codes and Standards Committee, Commissioner of the Department of Administrative Services, when adopting State Building Code amendments, to consider that the State's housing shortage compromises the safety of residents who cannot afford a safe home. The amendments must also encourage producing buildings that include safe housing that can be built at a reasonable cost (Section 117).

F. TELEHEALTH

20. PUBLIC ACT NO. 24-110. AN ACT CONCERNING TELEHEALTH.
Effective June 4, 2024, except as otherwise noted

§ 1 — The Provision of and Payment for Telehealth Services

This Section revises C.G.S. § 19a-906 to remove the exclusion of audio-only telephone services that previously existed in the statute. Audio-only telephone services may now be considered telehealth. Use of fax, texting, or email are still excluded from the definition of telehealth.

In addition, the definition of a "telehealth provider" was expanded from a list of only specific provider types to cover any Connecticut licensed health care provider or pharmacist under Chapter

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20 of the general statutes. Moreover, this Section revises the statute to clarify that a telehealth provider may provide telehealth services from any location to a patient in any location.

However, this Section significantly narrows the out-of-state providers that can provide telehealth services in Connecticut. In contrast to the broad flexibility provided to out-of-state providers to practice in Connecticut due to the pandemic, the statute now only allows certain registered mental or behavioral health providers currently licensed in another state to temporarily provide mental or behavioral health care in Connecticut via telehealth while seeking a Connecticut license. Specifically, out-of-state licensed providers may only practice telehealth in Connecticut if all of the following apply: (a) the services are provided on or before June 30, 2025; (b) the provider is licensed in another state or territory of the United States or the District of Columbia as a certified or registered physician, naturopath, registered nurse, advanced practice registered nurse, physician assistant, 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 or art therapist; (c) the provider provides 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; (d) the provider maintains professional liability insurance, or other indemnity against liability for professional malpractice, in an amount that is equal to or greater than that required for similarly licensed, certified or registered Connecticut mental or behavioral health care providers; (e) the provider registers with DPH as a provider of mental or behavioral health care through the use of telehealth prior to providing telehealth to a patient in Connecticut and (f) the provider submits an application to DPH for a license, certificate or registration as a mental or behavioral health care provider pursuant to Chapter 20 of the general statutes not later than sixty (60) days after registering with DPH and completes the application process for such license, certificate or registration not later than sixty (60) days after submitting such application. DPH has a website for providers that wish to register here.

Any Connecticut entity, institution or health care provider who engages or contracts with an out-of-state telehealth provider must verify that the provider has properly registered with DPH. DPH is required to (a) verify the credentials of a telehealth provider in the state in which such provider is licensed, certified or registered, (b) ensure that the telehealth provider is in good standing in such state and (c) confirm that the telehealth provider maintains the required amount of professional liability insurance or other indemnity against liability for professional malpractice. DPH must issue a decision on each application not later than forty-five (45) days after the completion of the application process for such provider.

In regard to payment for telehealth services, this Section further amended the statute to mandate that prior to providing telehealth services, a telehealth provider must determine whether the patient has health coverage for telehealth. If the patient has such health coverage, the provider must then determine whether the patient elects to either use such health coverage to pay for the telehealth

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services, in whole or in part, or pay the provider directly without using such coverage. In addition, the telehealth provider must disclose the cost of the telehealth services to the patient.

If the telehealth provider agrees to provide telehealth services to the patient, then the provider must accept as full payment either: (a) an amount equal to the amount that Medicare reimburses for such services if the telehealth provider determines that the patient does not have health coverage for such services; (b) the amount that the patient's health coverage reimburses and any coinsurance, copayment, deductible or other out-of-pocket expense imposed by the patient's health coverage for such services if the telehealth provider determines that the patient has health coverage for such services, unless the patient has explicitly elected to pay the provider directly without using such coverage; or (c) an amount mutually agreed to by the patient and telehealth provider.

If a telehealth provider determines that a patient is unable to pay for any telehealth services, then the provider must offer to the patient financial assistance if the provider is otherwise required to offer to the patient such financial assistance under any applicable state or federal law. The statute explicitly states that patients are permitted to pay telehealth providers for telehealth services directly without seeking coverage from a health insurer.

§ 3 — Payment Parity

This Section prohibits health carriers from reducing the amount of reimbursement paid to a telehealth provider because the services were provided through telehealth and not in person.

§ 8 — Telehealth Data

This Section requires DPH to report to the General Assembly's Public Health Committee not later than January 1, 2025, and, thereafter, not later than July 1, 2025, regarding: (a) the number of telehealth providers who registered with DPH; (2b the number of telehealth providers who applied to DPH; (c) the number of telehealth providers who received a license from DPH; and (d) the number of out-of-state health care providers who applied for a license with DPH.

G. HUMAN SERVICES STATUTE REVISIONS

21. PUBLIC ACT 24-134. AN ACT CONCERNING VARIOUS REVISIONS TO HUMAN SERVICES STATUTES.

This Act contains two items of interest that both took effect on June 6, 2024:

- **Department of Aging and Disability Services.** Section 1 of this Act eliminates obsolete statutory provisions generally designating DSS as the lead agency for services to people with physical and mental disabilities and for coordination of services across agencies;

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Section 1 does retain DSS's obligation to maintain on the DSS web site information on services provided to persons with disabilities with a link to ADS web site containing information about services for deaf, deafblind and hard of hearing.

- **Inflation Measure for CCNH and RCH Rates.** The Act also makes technical revisions to various statutes, including Section 17b-340(i) governing RCH reimbursement (see Section 3 of the Act) and Section 17b-340d governing CCNH reimbursement (see Section 4 of the Act), in each case to indicate that the inflation measure for calculation of the applicable Medicaid rate will be based on quarters ending March 31st, rather than April 30th of each year.

H. ELDERLY NUTRITION PROGRAM

22. PUBLIC ACT 24-99. AN ACT IMPLEMENTING TASK FORCE RECOMMENDATIONS FOR THE ELDERLY NUTRITION PROGRAM
Effective July 1, 2024, except as otherwise noted

§ 1 —Continuity of Effort Plan

This Section amends existing law by adding two (2) new subsections to the statute related to the allocation of funds by ADS.

The first new subsection requires ADS to disburse additional payments under the elderly nutrition program to area agencies on aging contracting with ADS and having spent fifty percent (50%) or more of their initial funding disbursement under such contract. Assuming there are available appropriations, ADS must disperse the additional payments within thirty (30) days after receiving appropriate documentation prescribing the relevant expenditures. At that time, the area agency must then transfer the additional payments to vendors within thirty (30) days of receipt. In addition, the first new subsection requires the Commissioner of ADS to file a report by July 1, 2025, and annually thereafter, with the General Assembly's Aging and Human Services Committees concerning the feasibility of additional disbursements to area agencies on aging that spend twenty-five percent (25%) or more of their initial disbursement.

The second new subsection mandates area agencies on aging to develop a continuity of effort plan, in consultation with elected municipal officials and appointed municipal agents for elderly persons, to minimize benefit disruptions under the elderly nutrition program in the area when a provider leaves the program or when there is a significant increase in service levels or demand for the program. This plan must also include an area agency on aging applying for funding to support elderly nutrition program services through any grant source. Area agencies on aging must submit their plans to the Commissioner of ADS by January 1, 2025 along with a written notification

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provided to the chief elected officials, municipal agents for the elderly and state and federal elected officials of the area such agency serves within ten (10) business days after a significant increase in service levels or demands for the elderly nutrition program. Lastly, this Section authorizes the Commissioner of ADS to withhold funding from an area agency on aging or take other remedial measures for violating the requirements in relation to the continuity of effort plan.

§ 2 — Streamlining Elderly Nutrition Program's Processes
Effective June 4, 2024

This Section requires the Commissioner of ADS, in consultation with the area agencies on aging, to develop a plan to streamline the Elderly Nutrition Program's contracted process, compliance reporting and eligibility and assessment forms. The plan to streamline these aspects of the Elderly Nutrition Program must include (a) issuing a template or portal that will allow program providers to reduce reporting and applications redundancies, (b) granting automatic approval for program services based on a client eligibility assessment and (c) modifying client eligibility forms to include only the minimum information required under federal law. The Commissioner of DADs must file a report on the streamlining plan by October 1, 2024 to the General Assembly's Aging and Human Services Committees.

§ 3 — Prohibition Against the Use of Personal Information and Exceptions

This Section amends existing law to further require the Commissioner of DSS to disclose to any authorized representative of ADS, or to an area agency on aging contracting with ADS to provide services under the elderly nutrition program, and information on supplemental nutrition assistance program enrollees who have requested or been recommended to receive elderly nutrition program services.

§ 4 — Maximizing the Supplemental Nutrition Assistance Program to Support the Elderly

This Section imposes a new requirement for the Commissioner of DSS, upon request from the Commissioner of ADS or an area agency on aging contracting to provide services under the elderly nutrition program, to provide information on whether eligible persons under the elderly nutrition program are receiving benefits from the supplemental nutrition assistance program.

Furthermore, this Section requires the Commissioner of DSS to develop a plan to maximize supplemental assistance program benefits to support the elderly nutrition program. Such plan must include, but need not be limited to, (a) outreach to persons who are eligible for both the elderly nutrition and the supplemental nutrition assistance programs and (b) federally permissible uses of supplemental nutrition assistance benefits to fund meals for the households of persons aged sixty (60) and over and persons with disabilities and their households.

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Finally, this Section requires the Commissioner of DSS, in consultation with the Commissioner of ADS, to file a report on the plan by October 1, 2024 with the General Assembly's Aging and Human Services Committees.

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