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

2019 REGULAR AND SPECIAL SESSIONS OF THE CONNECTICUT GENERAL ASSEMBLY

PREPARED BY:

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TABLE OF ACRONYMS

APRN	Advanced Practiced Registered Nurse
CHRO	Connecticut Commission on Human Rights and Opportunities
CMS	Centers for Medicare and Medicaid Services
CON	Certificate of Need
DDS	Department of Developmental Services
DOI	Department of Insurance
DORS	Department of Rehabilitation Services
DPH	Department of Public Health
DSS	Department of Social Services
DRS	Department of Revenue Services
FDA	United States Food and Drug Administration
FMLA	Family and Medical Leave Act of 1993, as amended
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
LPN	Licensed Practical Nurse
LTC	Long-Term Care
OHS	Office of Health Strategy
OPM	Office of Policy Management
PA	Physician Assistant
RCH	Residential Care Home
RN	Registered Nurse

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I. SPENDING BILLS

1. PUBLIC ACT 19-117. AN ACT CONCERNING THE STATE BUDGET FOR THE BIENNIUM ENDING JUNE 30, 2021, AND MAKING APPROPRIATIONS THEREFOR, AND PROVISIONS RELATED TO REVENUE AND OTHER ITEMS TO IMPLEMENT THE STATE BUDGET.

§§ 105–143 Commission on Women, Children, Seniors, Equity and Opportunity
Effective July 1, 2019

These Sections merge the Commission on Equity and Opportunity ("CEO") and Commission on Women, Children, and Seniors ("CWCS") into a single entity, the Commission on Women, Children, Seniors, Equity and Opportunity, which the Act designates as the successor to the two current commissions. The Commission will focus on issues affecting the following underrepresented and underserved populations: women, children and the family, elderly persons, African Americans, Asian Pacific Americans, and Latinos and Puerto Ricans.

Before June 30, 2021, the former chairpersons of the CEO and CWCS will serve as chairpersons of the advisory board. The term of any members of the CEO and CWCS appointed before July 1, 2019 whose term has not expired as of June 30, 2019, will expire on June 30, 2019.

The Commission will be organized into an executive committee and six subcommissions to advise on policies affecting: (i) members of the African-American population, (ii) members of the Asian Pacific-American population, (iii) members of the Latino and Puerto Rican population, (iv) women, (v) children and family, and (vi) elderly persons. The chairpersons of the advisory board will designate members to serve on each subcomission.

These Sections also revise various statutory references to CEO and CWCS to reflect the merger.

§§ 160–161 Community Health Workers
Effective January 1, 2020

These Sections establish a Community Health Worker Advisory Body within OHS to: (i) advise OHS and DPH on matters relating to the educational and certification requirements for training programs for community health workers, including the minimum number of hours and internship requirements for certification of community health workers; (ii) conduct a continuous review of such educational and certification programs; and (iii) provide DPH with a list of approved educational and certification programs for community health workers.

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The executive director of OHS, or a person designated by the executive director to serve in his or her place, will act as the chair of the advisory body. He or she will appoint 13 persons to the advisory body, including the Commissioner of DPH or a person designated by the commissioner to serve in his or her place.

Section 160 of this Act also prohibits any person who is not certified by DPH as a community health worker from using the title "certified community health worker."

Section 160 of this Act further provides that an applicant for certification as a community health worker will apply to DPH on DPH-prescribed forms, which must be signed by the applicant and accompanied by $100 fee. An applicant must either: (i) be trained and educated by an organization approved by the Community Health Worker Advisory Body, be at least 16 years of age, submit two references from persons who have direct knowledge of the applicant's experience as a community health worker (one an employer and one a member of the community), and have at least 1,000 hours of experience working as a community health worker during the three years prior to the date of the application; or (ii) have at least 2,000 hours of experience working as a community health worker and submit two references from persons who have direct knowledge of the applicant's experience as a community health worker (one an employer and one a member of the community).

A community health worker certification may be renewed every three years for a $100 fee. Every certified community health worker applying for license renewal must prove to DPH that he or she completed a minimum of 30 hours of continuing education requirements, including two hours focused on cultural competency, systemic racism, or systemic oppression and two hours focused on social determinants of health.

Section 160 of this Act further allows DPH to take disciplinary action against a certified community health worker if he or she: (i) engages in fraud or deceit in obtaining or seeking reinstatement of a license to practice as a community health worker; (ii) engages in fraud or material deception in the course of professional services or activities; (iii) engages in negligent, incompetent, or wrongful conduct in professional activities; (iv) aids or abets the use of the title "certified community health worker" by an individual who is not certified; (v) is unable to conform to the accepted standards of the profession due to physical, mental, or emotional illness or disorder; or (vi) abuses or excessively uses drugs, including alcohol, narcotics, or chemicals. If applicable, DPH may order a license holder to submit to a reasonable physical or mental examination.

Section 160 of this Act does not apply to community health workers who are providing services such as outreach, engagement, education, coaching, informal counseling, social support, advocacy, care coordination, research related to social determinants of health, and based

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screenings and assessments of any risks associated with social determinants of health, unless these workers hold themselves out to the public as certified community health workers.

Section 161 of this Act requires each person holding a community health worker certificate to apply for renewal of such certificate once every three years, during the month of his or her birth, to DPH.

§§ 176–182 Art Therapist License
Effective October 1, 2019

These Sections define "art therapist" as a person who has been licensed as an art therapist or issued a temporary permit for licensure as an art therapist and set forth the process and criteria for obtaining an art therapist license, including licensure by endorsement.

These Sections prohibit any person who is not an art therapist from using the title "art therapist," "licensed art therapist," or any title, words, letters, abbreviations or insignia that may reasonably be confused with licensure as an art therapist. This prohibition does not apply to (i) persons licensed or certified by the departments of nationally-recognized licensing or certifying organizations acting within the scope of their professional training, provided they do not represent themselves to the public as art therapists, or (ii) students enrolled in art therapy educational programs at accredited educational institutions, or graduate art therapy programs approved by the American Art Therapy Association, provided art therapy is an integral part of the students' course of study and the students are acting under the direct supervision of licensed art therapists.

These Sections also authorize DPH to take disciplinary action against a licensed art therapist.

§§ 230–231 Insurance Data Security
Section 230, effective October 1, 2019
Section 231, effective October 1, 2020

Section 230 of this Act defines "licensee" as any person licensed, authorized to operate, or registered (or required to be licensed, authorized to operate, or registered), pursuant to the insurance laws of this State. "Third-party service provider" means a person, other than a licensee, that: (i) contracts with a licensee to maintain, process or store nonpublic information; or (ii) is otherwise permitted to access nonpublic information through the person's provision of services to a licensee. These Sections expand and revise State laws governing information security for insurance with detailed provisions substantially similar to the National Association of Insurance Commissioners insurance data security model law.

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Section 230 of this Act requires each licensee to implement an information security program no later than October 20, 2020 and outlines the specific elements that must be included in the program, including provisions for an incident-response plan for cybersecurity events. Section 230 of this Act also requires each licensee to exercise due diligence in selecting its third-party service providers. No later than October 1, 2021, each licensee must require its third-party service providers to implement appropriate administrative, technical, and physical measures to protect and secure the information systems that are, and nonpublic information that is, accessible to, or held by, its third-party service providers.

Section 230 of this Act also requires a licensee to investigate a cybersecurity event that has or may have occurred. If the potential cybersecurity event occurred in a system maintained by a third-party service provider, the licensee must investigate the event or confirm and document that the third-party service provider investigated the event. Section 230 of this Act also requires each licensee to notify the Insurance Commissioner of a cybersecurity event.

Section 231 of this Act amends current law governing the obligation for businesses to offer identity theft protections to individuals whose data has been breached. The amendment inserts reference to Section 230 of this Act and therefore makes it clear that the obligation to provide identity theft protections applies to insurance data beaches. Section 231 of this Act provides that any person who conducts business in the State, and who, in the ordinary course of his or her business, owns or licenses computerized data that includes personal information, must offer to each resident whose nonpublic information or personal information was breached or is reasonably believed to have been breached, appropriate identity theft protection services and, if applicable, identity theft mitigation services.

§§ 232–235 Paid Family and Medical Leave Revisions
Effective June 4, 2019

These Sections amend Public Act 19-25, An Act Concerning Paid Family and Medical Leave. Please see the summary of this Public Act 19-25 prepared by Wiggin and Dana LLP's Labor, Employment and Benefits Department, at https://www.wiggin.com/labor-employment-and-benefits/publications/connecticut-significantly-expands-coverage-of-family-and-medical-leave-act-adopts-paid-leave/.

These Sections broaden the definition of "base weekly earnings" and "subject earnings" to include self-employment income, provided that the recipient has enrolled in the Paid Family Medical Leave Insurance Program.

Section 233 of this Act reduces, from 15 to 13 members, the voting members of the board of directors of the Paid Family and Medical Leave Insurance Authority. It makes the Secretary of

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OPM and the State Treasurer, or persons designated by them to serve in their places, nonvoting members of the board.

Under current law, no member of the board or any officer, agent, or employee of the Paid Family and Medical Leave Authority may have any financial interest in any entity contracting with the Authority. This Section clarifies that "financial interest" does not include an interest of a *de minimis* nature or an interest that is not distinct from that of a substantial segment of the public.

Section 234 of this Act removes a requirement of the board of directors of the Paid Family and Medical Leave Insurance Authority to issue requests for proposals if it chooses to use outside contractors for certain services. It also provides that if the board chooses to establish additional standard criteria for the evaluation of proposals relating to claims processing, website development, database development, and marketing and advertising, the criteria must be posted on a public Internet website maintained by the Authority for notice and comment for at least one week prior to approval by the board by a two-thirds vote.

Section 235 of this Act delays, until January 1, 2022, the creation of a "non-charge" against an employer's unemployment tax experience rate when an employer lays off an employee due to an employee's return from FMLA leave. The creation of the "non-charge" will, once in effect, allow an employer to lay off an employee who was temporarily filling the position of someone on FMLA leave without increasing the employer's unemployment taxes.

§§ 236–237 Health Insurance Cost-Sharing
Effective January 1, 2020

Section 236 of this Act limits the amount of out-pocket expenses that certain insurers can charge. Specifically, it prohibits certain individual or group health insurance policies from imposing a coinsurance, copayment, deductible, or other out-of-pocket expense for a covered benefit in an amount that exceeds the lesser of: (i) the amount paid to the provider or vendor for the covered benefit, including all discounts, rebates, and adjustments, by the insurer; (ii) an amount calculated on the basis of the amount charged for the covered benefit by the provider or vendor, less any discount for such covered benefit and any amount due to, or charged by, an entity if such entity is affiliated with, or owned or controlled by, the insurer; and (iii) the amount that the insured would have paid to the provider or vendor for the covered benefit without regard to such policy. Violations of these Sections are considered unfair methods of competition and unfair and deceptive acts or practices in the business of insurance.

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§ 238 Health Insurance Penalties for Disclosures to Insureds
Effective January 1, 2020

This Section prohibits health carrier contracts from prohibiting or penalizing disclosure of any information to a covered person, concerning: (i) the cost of a covered benefit, including, the cash price of a covered benefit; or (ii) the availability and cost of any health care service or product that is therapeutically equivalent to a covered benefit, including the cash price of any such health service or product. Health carrier contracts might impermissibly prohibit or penalize disclosure of this information through increased utilization review or reduced payments or other financial incentives.

§ 239 Managed Care Organizations' Calculation of Deductibles
Effective January 1, 2020

This Section requires managed care organizations to calculate insureds' deductibles in the same way that existing law requires them to calculate insureds' percentage coinsurance payments. This Section also requires the amounts payable by subcontractors of managed care organizations to be considered in the calculation.

§ 240 Surprise Billing for Clinical Laboratory Services
Effective January 1, 2020

This Section broadens the definition of "surprise bill" to include bills for health care services, other than emergency services, received by an insured for services rendered by an out-of-network clinical laboratory if an insured is referred to the laboratory by an in-network provider.

§§ 241–243 Adverse Determination Review Timeframes
Effective January 1, 2020

These Sections reduce, from 72 to 48 hours, the maximum time for certain health benefit and adverse determination reviews with exceptions for weekends. The affected reviews include health carrier reviews of urgent care requests and/or concurrent review requests to extend a course of treatment beyond the initial period or the number of treatments, expedited review requests to health carriers, and independent review organization reviews of determinations on expedited external reviews based on assignments from DOI.

§ 246 Medical Necessity and Emergency Medical Conditions
Effective January 1, 2020

This Section requires health insurance policies with (i) basic hospital expense coverage, (ii) basic medical-surgical expense coverage, (iii) major medical expense coverage, (iv) hospital

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or medical service plan contract, or (v) hospital and medical coverage provided to subscribers of a health care center, to cover medically necessary health care services to treat emergency medical conditions. Emergency medical conditions are conditions that prudent laypersons, acting reasonably, would believe necessitate emergency medical treatment.

§ 247 Task Force on High Deductible Health Plans
Effective June 4, 2019

This Section establishes a task force to study the structure and impact of high deductible health plans that are not used to establish medical savings accounts, Archer Medical Savings Accounts, or health savings accounts. The task force will make recommendations concerning: (i) measures to ensure access to affordable health care services under high deductible health plans, (ii) the financial impact that high deductible health plans have on enrollees and their families, (iii) the use of health savings accounts and the impact that alternative payment structures would have on such accounts, (iv) measures to ensure that each cost-sharing payment due under a high deductible health plan and paid by an enrollee at the time of service accurately reflects the enrollee's cost-sharing obligation for such service under such plan, (v) measures to ensure the prompt payment of a refund to an enrollee for any cost-sharing payments under a high deductible health plan that exceeds the enrollee's cost-sharing obligation under such plan, (vi) measures to enhance enrollee knowledge regarding how enrollee payments are applied to deductibles under high deductible health plans, and (vii) payment models where a physician can receive reimbursement from a health carrier for services provided to enrollees.

The task force must submit a report of its findings and recommendations to the Joint Committee on Insurance. The task force will terminate either on the date that it submits the report or December 1, 2020, whichever is later.

§ 292 State Supplement
Effective July 1, 2019

This Section states that the adult payment standards for the State supplement to the federal Supplemental Security Income Program for fiscal years 2020 and 2021 will not be increased.

§§ 293, 294, 296 and 297 Rate Freezes for RCHs, Community Living Arrangements and Community Companion Homes
Effective July 1, 2019

These Sections freeze, until fiscal year 2021, the flat rate that the State pays certain RCHs, community living arrangements, and community companion homes for providing residential services.

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§ 300 RCH Rates
Effective July 1, 2019

This Section freezes RCH rates but authorizes DSS to approve RCH fair rent increases in fiscal years 2020 and 2021. For fiscal year 2020, rates will not exceed those in effect for fiscal year 2019, except DSS may provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the cost report year ending September 30, 2018 that are not otherwise included in rates issued. For fiscal year 2021, rates will not exceed those in effect for fiscal year 2020, except DSS may provide pro rata fair rent increases to facilities which have documented fair rent additions placed in service in the cost report year ending September 30, 2019 that are not otherwise included in rates issued.

§ 302 Nursing Home Medicaid Rates
Effective July 1, 2019

This Section requires DSS to determine nursing home facility rates for fiscal year 2020 based upon 2018 cost report filings, adjusted to reflect any rate increases after the cost report year ending September 30, 2018; provided, that no facility receives a rate that is higher than the rate in effect June 30, 2019, unless DSS provides, within available appropriations, pro rata fair rent increases, including increases for facilities that have undergone a material change in circumstances related to fair rent additions in the cost report year ending September 30, 2018 that are not otherwise included in rates issued. For fiscal year 2020, no facility will receive a rate that is more than two percent lower than the rate in effect June 30, 2019, unless the facility has an occupancy level of less than 70% or an overall rating on Medicare's Nursing Home Compare of one star for the three most recent reporting periods as of July 1, 2019, unless the facility is under an interim rate due to new ownership. For fiscal year 2021, no facility will receive a rate that is higher than the rate in effect June 30, 2020 unless DSS provides, within available appropriations, pro rata fair rent increases, including increases for facilities which have undergone a material change in circumstances related to fair rent additions in the cost report year ending September 30, 2019 that are not otherwise included in rates issued.

This Section also requires DSS, within available appropriations, to increase rates for wage and benefit enhancements for nursing home facility employees effective July 1, 2019, October 1, 2020 and January 1, 2021. DSS will issue rate adjustments to the facility to reflect any rate increases paid after the cost report year ending September 30, 2018. Facilities that receive rate adjustment for wage and benefit enhancements but do not provide increases in employee salaries on or before September 30, 2019, October 31, 2020, and January 1, 2021, respectively, may be subject to a rate decrease in the same amount as the adjustment by DSS.

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§ 303 Nursing Home/RCH Receiverships
Effective July 1, 2019

This Section raises, from $3,000 to $10,000, the amount that an appointed receiver of a nursing home or RCH may spend to correct or eliminate deficiencies in facility structure or furnishings that endanger resident safety or health.

This Section also requires an appointed receiver of a nursing home or RCH to begin closing the facility if its overall occupancy is below 70% and closure is consistent with the State's strategic rebalancing plan. The receiver has 45 days, rather than six months, to determine and report to the court whether the facility can continue to operate and provide adequate care to residents within the facility's State payments, together with income from self-pay residents, Medicare payments, and other current income. Within a reasonable period of time, not to exceed six months, the receiver must seek facility purchase proposals if he or she determines that the continued operation of the facility is viable.

§ 304 Nursing Home/RCH Closures
Effective July 1, 2019

This Section amends the law governing CONs for nursing home and RCH closures. It permits a facility to submit a petition for closure to DSS. DSS must grant or deny petitions for closure within 30 days of receiving them. These provisions do not apply to nursing homes that do not participate in the Medicaid program and are associated with a continuing care facility, since these facilities are exempt from the CON law.

DSS may authorize the closure of a facility if the facility's management demonstrates, in its petition for closure, that the facility (i) is not viable based on actual and projected operating losses; (ii) has an occupancy rate of less than 70% of the facility's licensed bed capacity; (iii) closure is consistent with the State's strategic rebalancing plan, including bed need by geographical region; (iv) is in compliance with the requirements of certain sections of the Social Security Act and regulations concerning the requirements of participation, including but not limited to federal requirements for nursing home closures; and (v) is not providing special services that would go unmet if the facility closes. The facility must submit information DSS requests or deems necessary to make its determination about closure and to provide oversight during the process.

The facility must notify the Office of the LTC Ombudsman at the same time it submits a petition for closure to DSS. The facility must notify, on the same day and in writing, all known patients, guardian or conservators, and legally liable relatives or other responsible parties. The facility must also post notice in a conspicuous location at the facility. The facility's notice must be accompanied by a jointly issued informational letter from the Office of the LTC

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Ombudsman and DRS on patients' rights and services available as they relate to the petition for closure. The informational letter must state, among other things, the date and time that the Office of the LTC Ombudsman and DPH will hold an informational session at the facility for known patients, guardian or conservators, and legally liable relatives or other responsible parties about their rights and the process concerning a petition for closure. It must also contain specific information, including a description of the reasons for closure, notice that the petition must be approved by DSS and that the patient will have the right to appeal any proposed transfer or discharge.

§ 305 Covenant Not to Compete for Home Health Care, Homemaker and Companion Services
Effective June 4, 2019

This Section requires that any covenant not to compete that restricts the right of an individual to provide homemaker, companion, or home health services is void and unenforceable.

§ 308 Rate Increase for Meals on Wheels
Effective July 1, 2019

This Section requires DSS to increase the fee schedule for Meals on Wheels by 10% in fiscal year 2020.

§ 309 Medicaid Eligibility Fair Hearings
Effective June 4, 2019

This Section clarifies the deadline for DSS to issue a final decision on an administrative appeal involving Medicaid eligibility or fair hearing. This Section does not apply to provider-initiated Medicaid rate appeals. This Section extends the timeframe for DSS's issuance of a decision on an administrative appeal from 60 days to 90 days after the date it receives a request for a fair hearing. DSS must now, however, issue a final decision within three days after a hearing that concerns a denial of or failure to provide emergency housing. DSS's time for issuing a decision will be extended if (i) the aggrieved person requests or agrees to an extension or (ii) DSS documents an administrative or other extenuating circumstance beyond DSS's control that necessitates an extension. DSS's failure to issue a final decision within these time limits does not constitute approval of the aggrieved person's requested relief on the merits.

This Section also clarifies remedies for when DSS fails to meet the deadline. If DSS fails to issue a final decision within these time limits, the aggrieved person may file a request for a final decision with DSS, and DSS must issue the decision within 20 days after the request.

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§§ 312–13 DSS Burial Assistance
Effective July 1, 2019

These Sections raise, from $1,200 to $1,350, the cap for DSS burial assistance to individuals receiving assistance from the State under the general assistance State supplement, or temporary family assistance programs.

II. SPECIFIC ACTS OF INTEREST

2. PUBLIC ACT 19-42. AN ACT CONCERNING PARTICIPATION BY A RESIDENT OF A NURSING HOME FACILITY OR RESIDENTIAL CARE HOME IN A RECEIVERSHIP PROCEEDING.
Effective July 1, 2019

Under current law, a resident of a nursing home or RCH (or the resident's legally liable relative, conservator, or guardian), may appear as a party to receivership hearings. This Act requires a court to allow such individuals to be heard during these hearings without having to file an appearance as a party.

3. PUBLIC ACT 19-89. AN ACT CONCERNING NURSING HOME STAFFING LEVELS.
Effective October 1, 2019

§ 2

This Section requires nursing homes to calculate the number of APRNs, RNs, LPNs, and nurse's aides responsible for providing direct care to residents during a shift, post this information daily, and retain this information for 18 months from the date of posting. Information to be posted daily includes (i) name of the nursing home facility, (ii) date, (iii) total number of APRNs, RNs, LPNs, and nurse's aides responsible for direct patient care during the shift, (iv) total number of hours each of these individuals are scheduled to work during the shift, and (v) total number of nursing home facility residents. Calculations should not include nurses or nurse's aides who are managers or administrators or are working on transportation duty and not providing direct care during the primary portion of the shift. The "primary portion" of the shift equates to 6 or more hours of an 8-hour shift.

This Section also requires nursing home facilities to post (i) information daily regarding the minimum number of nursing home staff required by law to provide direct patient care per shift and (ii) the telephone number (860-509-7603) or website (https://dphflisevents.ct.gov/Complaints) that individuals may use to report violations of the staffing requirement.

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§ 3

This Section permits DPH to take disciplinary action against a nursing home facility that violates the staffing requirements set forth in § 2, above. Such disciplinary actions may include (i) suspending or revoking the facility's license, issuing a letter of reprimand or compliance order, imposing a corrective action plan, or placing it on probationary status, and (ii) issuing a citation to the licensee of the nursing home facility.

Violations relating to a nursing home facility's staffing level requirement must be posted in the facility and included in a listing by DPH.

§ 4

Under current law, nursing homes and RCHs cannot retaliate against any resident, relative, guardian, conservator, sponsoring agency, employee, or other person who files a complaint against the facility. This Section strengthens the rights of employees by requiring the facility to reinstate the employee if the employee was terminated by the facility in violation of these anti-retaliation rules. Further, this Section strengthens the rights of residents in that it requires the facility to restore the resident to his or her living situation prior to the discriminatory or retaliatory action if the resident's living situation was changed in violation of this Section.

4. PUBLIC ACT 19-97. AN ACT REMOVING THE TERM "HOMEMAKER" IN REFERENCE TO HOME HEALTH AIDE AGENCIES AND SERVICES.
Effective July 1, 2019

This Act changes the term "homemaker-home health aide agency" to "home health aide agency" in various statutory provisions regarding these agencies, providers, and services.

5. PUBLIC ACT 19-116. AN ACT CONCERNING REGISTRIES OF PERSONS FOUND RESPONSIBLE FOR ASSAULTS OR OTHER ABUSE, NEGLECT, EXPLOITATION OR ABANDONMENT OF ELDERLY PERSONS OR PERSONS WITH DISABILITIES.
Effective October 1, 2019

§ 1

This Section requires the Commission on Women, Children, and Seniors to (i) provide a portal on the Commission's website with links to publicly-available background databases, and (ii) convene a working group to raise awareness of the availability of these databases to persons hiring providers to care for elderly persons, children, or persons with disabilities. The Commission must record the number of times the portal is utilized and submit a report on its

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utilization, no later than January 1, 2021, to the Joint Committees on Aging, Children, Human Services, and Public Health.

Publicly-available background databases to be provided include: (i) the National Sex Offender Public Website, (ii) the Connecticut Sex Offender Registry, (iii) the list of individuals and entities excluded from federally-funded health care programs for reasons that include, but are not limited to, Medicaid or Medicare fraud, (iv) the Connecticut nurse's aide registry, (v) the criminal and motor vehicle conviction database, (vi) the professional licensure verification database, and (vii) the database of practitioners and entities suspended or excluded from participation in programs administered by DSS.

6. PUBLIC ACT 19-118. AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS FOR VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES.
Effective July 1, 2019, except as otherwise noted

§ 2

DPH awards Drinking Water State Revolving Fund Grants based on a priority list for funding it establishes and maintains. This Section allows DPH to disregard the priority list for an emergency, including an unanticipated infrastructure failure, water contamination, or a water shortage, that requires an eligible project to be immediately undertaken to protect the public's health and safety. Current law allows DPH to disregard the priority list only if a public drinking water supply emergency exists.

§ 5

This Section requires a nursing home to notify DPH of a proposed change of ownership at least 120 days before the date of transfer, instead of 90 days.

This Section also allows methadone as part of the accepted behavioral health treatment to people in nursing homes.

§ 7

Under current law, a health care practitioner licensing board or commission or DPH may take disciplinary action against a practitioner's license or permit if the practitioner was subject to disciplinary action by an authorized professional agency of any state, federal government, Washington D.C., U.S. possession or territory, or a foreign jurisdiction. Disciplinary actions include:

- revoking a license or permit;

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- suspending a license or permit;
- censuring a practitioner or permittee;
- issuing a letter of reprimand;
- placing a practitioner or permittee on probationary status;
- requiring restitution to an injured property owner;
- and any of the above disciplinary action against a practitioner that is a convicted felon.

This Section now permits licensing boards, commissions, or DPH to also take such disciplinary action if the practitioner's license or permit is subject to voluntary surrender or an agreement not to renew or reinstate.

§§ 8–12

These Sections moves the administration of the Connecticut AIDS Drug Assistance Program ("CADAP") and Connecticut Insurance Premium Assistance Program ("CIPA") from DSS to DPH by removing references to CADAP in DSS-related statutes. CADAP is a pharmaceutical drug assistance program that pays for certain FDA-approved medications to treat HIV and HIV-related conditions for eligible low-income residents. CIPA, which is funded through CADAP, provides health insurance premium assistance to eligible CADAP participants who have private insurance.

These Sections also reinstate the requirement that CADAP and CIPA applicants and beneficiaries enroll in Medicare Part D or demonstrate their ineligibility to do so. Finally, these Sections allow DPH to pay the premium and coinsurance costs of Medicare Part D coverage for these individuals.

§§ 13–14

These Sections permit, rather than require, DPH to adopt regulations on radon in drinking water consistent with the Environmental Protection Agency's national primary drinking water regulations. These Sections further permit, rather than require, DPH to establish radon measurement requirements and procedures for evaluating radon in indoor air and reducing elevated levels detected in public schools.

§ 15

This Section allows, rather than requires, DPH to adopt regulations to mandate that RCHs designate unlicensed personnel to obtain certification (and recertify every two years thereafter) to administer medication to residents.

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If DPH adopts any regulations on medication administration by unlicensed personnel, then DPH must also, at the same time, adopt policies and procedures necessary to administer these requirements.

Unlicensed assistive personnel in RCHs still may (i) obtain and document residents' blood pressures and temperatures with digital medical instruments, (ii) obtain and document residents' weight, and (iii) assist residents in the use of glucose monitors to obtain blood glucose levels.

§ 16

This Section allows, rather than requires, DPH to adopt regulations to implement the requirement under law that home health aide agencies, RCHs and assisted living service agencies, and licensed hospice care organizations provide training and education on Alzheimer's disease and dementia symptoms and care to all staff.

§ 19

This Section eliminates the requirement that DPH annually research, develop, track, and report to the Joint Committee on Public Health quantifiable outcome measures for the State's emergency medical service system.

§ 21

Under current law, DPH must consult with OHS and local health departments to develop and implement a statewide chronic disease plan. Previously that plan had to focus on the reduction of chronic cardiovascular disease, cancer, lupus, stroke, chronic lung disease, diabetes, arthritis or another metabolic disease, and the effects of behavioral health disorders.

This Section, however, eliminates these focus areas and instead substitutes focus areas of tobacco use, high blood pressure, health care associated infections, asthma, unintended pregnancy, and diabetes.

§ 23

This Section extends by one year, from January 1, 2019 to January 1, 2020, the date by which DPH must adopt the FDA's Model Food Code as the State's food code for regulating food establishments.

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§ 25

This Section changes the requirement for DDS to conduct fingerprint and State and national background checks on any job applicant to only job applicants who have been made a conditional employment offer.

§§ 27–40

These Sections repeal provisions and make changes so that DPH will administer CADAP and CIPA, which provide prescription medication assistance to eligible low-income residents with HIV or HIV-related conditions. Previously, the programs were administered by DSS.

These Sections also repeal the provisions establishing a Health Care Access Commission to develop programs needed to ensure appropriate health care access by all residents. The Commission's duties are now performed by the OHS's Health Care Cabinet.

§§ 41–42

These Sections add "behavioral health facilities" to have reporting duties to, and licensing requirements from, DPH. These sections also add DPH licensing and inspection of outpatient clinics every three years. Outpatient clinics that have accreditation from a national accrediting organization within the last year may be inspected by DPH once every four years, if those clinics have not committed any violations that would pose an immediate threat to patients. DPH authority to inspect, suspend, or revoke outpatient clinics is not limited by these Sections.

§ 58

This Section adds an application process and requirements for emergency medical technicians to apply to DPH for certification.

§ 64

This Section defines "mobile integrated health care program" as a DPH-approved program that offers services by licensed or certified ambulance service providers or paramedics. These services include clinically-appropriate medical evaluations, treatment, transportation, and referrals.

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§ 65

This Section adds that DPH shall establish rates for the treatment and release of patients by a licensed or certified emergency medical services organization, or an associated health care provider. This Section exempts mobile integrated health care programs from DPH rates.

§ 68

This Section adds that only DPH can authorize an emergency medical services organization that meets certain requirements to establish a mobile integrated health care program under its existing license or certification. Emergency medical services organizations cannot establish mobile integrated health care programs without DPH approval. DPH will post policies and procedures regarding the administration of mobile integrated health care programs to its website no later than January 20, 2020.

This Section also states that any ambulance service that notifies DPH in writing before October 1, 2019 that it has been the primary service area responder for a primary service area for at least a month will be deemed that area's authorized mobile integrated health care program.

§ 69

This Section adds that any person receiving services or transportation from a mobile integrated health care program must be responsible for the reasonable costs of those services.

§§ 70-74
Effective July 9, 2019

These sections contain technical corrections to various statutes, including the nursing home property tax exemption statute, to update and correct the citation to the statutory definition of "nursing home."

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III. ACTS CONCERNING HEALTH INSURANCE

7. PUBLIC ACT 19-76. AN ACT EXPANDING MEDICAID COVERAGE OF TELEHEALTH SERVICES.
Effective July 1, 2019

Current law requires DSS to provide coverage under the Medicaid program for telehealth services, within available State and federal resources, for categories of health care services that DSS determined were (i) clinically appropriate to be provided via telehealth, (ii) cost effective, and (iii) likely to expand health care access.

This Act removes the availability of State and federal resources as a condition for providing telehealth coverage. This Act also revises the third requirement listed above, by now requiring that the services were likely to expand health care access and there be a clinical need for the services to be provided via telehealth. Under this Act, DSS may provide coverage of telehealth services regardless of any State regulations that would otherwise prohibit such coverage.
Finally, this Act requires DSS to submit a report to the Joint Committees on Human Services and Public Health by August 1, 2020, on (i) the health care categories utilizing telehealth services, (ii) the cities or regions where the services are being offered, and (iii) any cost savings realized by the State.

8. PUBLIC ACT 19-133. AN ACT EXPANDING REQUIRED HEALTH INSURANCE COVERAGE FOR HEARING AIDS.
Effective January 1, 2020

Current law requires insurance policies to cover hearing aids only for children under age 13. This Act eliminates an age restriction for mandated health insurance coverage for hearing aids, thus requiring certain insurance policies to cover hearing aids for any covered person. In doing so, it codifies the Insurance Department's Bulletin HC-102, which brought the State hearing aid benefit requirement into compliance with the federal Patient Protection and Affordable Care Act, which generally prohibits age-based discrimination in benefit design.

Under current law, policies may limit hearing aid coverage to $1,000 within a 24-month period. This Act instead allows policies to limit coverage to one hearing aid per ear (with no dollar-amount limitation) within a 24-month period.

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9. PUBLIC ACT 19-134. AN ACT EXPANDING REQUIRED HEALTH INSURANCE COVERAGE FOR PREEXISTING CONDITIONS.
Effective January 1, 2020

This Act prohibits short-term health insurance policies issued on a nonrenewable basis for a term of six months or less from containing a provision that limits or excludes coverage for preexisting conditions. Current law already prohibits other individual and group health insurance policies and HMO contracts from imposing a preexisting condition provision.

Current law limits the provision to preexisting conditions for which medical advice, diagnosis, care, or treatment was recommended or received. This Act redefines the term "preexisting condition provision" to include preexisting conditions whether or not medical advice, diagnosis, care, or treatment was recommended or received before the coverage effective date.

IV. ACTS CONCERNING EMPLOYMENT AND BUSINESS RESPONSIBILITIES

10. PUBLIC ACT 19-4. AN ACT INCREASING THE MINIMUM FAIR WAGE.

§ 1
Effective October 1, 2019

This Act increases the State's minimum hourly wage from its current $10.10 to (i) $11.00 on October 1, 2019; (ii) $12.00 on September 1, 2020; (iii) $13.00 on August 1, 2021; (iv) $14.00 on July 1, 2022; and (v) $15.00 on June 1, 2023. Beginning January 1, 2024, the annual minimum wage is adjusted based on the federal employment cost index. DOL can recommend suspending any scheduled minimum wage increases after two consecutive quarters of negative growth in the State's real gross domestic product.

This Act also permits employers to pay a training wage only to people under the age of 18, who are not emancipated minors, for the first 90 days of employment. Training wage is eighty-five percent (85%) of the minimum wage. Current law allows employers to pay training wage to any learners and beginners for the first 200 days of employment.

§ 2
Effective May 16, 2019

Starting October 1, 2020, this Section prohibits employers from taking any action to displace, or partially displace, an employee in order to hire people under age 18 at a subminimum wage rate. This includes reducing an employee's hours, wages, or employment benefits. DOL can suspend the violating employer's right to pay the reduced rate for employees for a time specified in regulations.

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11. PUBLIC ACT NO. 19-16. AN ACT COMBATING SEXUAL ASSAULT AND SEXUAL HARASSMENT.
Effective October 1, 2019, except as otherwise noted

§ 1

Currently, employers with three or more employees must post information about the illegality of sexual harassment and available remedies for victims in a prominent and accessible location. As of October 1, 2019, these same employers must also provide a copy of this information to each employee by electronic mail within three months of the employee's start date with a subject line that includes the words "Sexual Harassment Policy" or words of similar import, if (i) the employer has provided an electronic mail account to the employee, or (ii) the employee has provided the employer with an electronic mail address, provided if an employer has not provided an electronic mail account to the employee, the employer shall post the information concerning the illegality of sexual harassment and remedies available to victims of sexual harassment on the employer's website, if the employer maintains such a website. Alternatively, an employer may comply with the above requirement by providing an employee with the link to the CHRO website concerning the illegality of sexual harassment and the remedies available to victims of sexual harassment by electronic mail, text message or in writing.

Moreover, current law requires employers with fifty or more employees to provide sexual harassment prevention training to all supervisors within six months of assuming a supervisory position. This Section expands these obligations to encompass Connecticut employers of only three or more and requires that all employees both supervisory and non-supervisory receive two hours of sexual harassment prevention training. For existing employees, this training must be provided by October 1, 2020. All employees hired on or after October 1, 2019 must receive the training within six months of hire.

Furthermore, employers with fewer than three employees (including family businesses where an individual is employed by a spouse, parent or child) must provide sexual harassment training to supervisory employees by October 1, 2020, or within six months of an employee assuming a supervisory role.

All employers will be required to provide periodic supplemental training not less than every ten years. Unchanged are the regulations promulgated by the CHRO that encourage, but not require, employers to provide training updates once every three years.

§ 3
Effective July 1, 2019

This Section requires the CHRO to develop and include on the commission's website a link concerning the illegality of sexual harassment and the remedies available to victims of sexual

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harassment. Additionally, the CHRO must develop and make available, at no cost to employers, an online training and education video or other interactive methods of training and education that fulfills the requirements prescribed by this Act.

§ 4

This Section establishes that employers who take immediate "corrective action," which includes but is not limited to employee relocation, assigning an employee to a different work schedule or other substantive changes to an employee's terms and conditions of employment, are prohibited from modifying the conditions of employment of the employee making the claim of sexual harassment unless such employee agrees, in writing, to any modification in the conditions of employment.

§ 5

The equal employment opportunity officer investigating a complaint may not disclose witness statements or documents received or compiled in conjunction with the investigation of a complaint of discriminatory conduct within the agency, department, board or commission until the conclusion of such investigation, except that witness statements or documents may be disclosed to personnel charged with investigating or adjudicating such complaint, or to the CHRO.

§ 6

This Section extends the amount of time that individuals who believe that they have been subjected to a discriminatory practice in violation of the Connecticut Fair Employment Practices Act ("CFEPA") have to file a complaint with the CHRO, from within 180 days of the alleged adverse action to within 300 days after the date of the alleged act of discrimination. The extended time in which to file with the CHRO applies to all complaints based on violations alleged to have occurred on or after October 1, 2019.

§ 7

This Section expands the potential damages that can be assessed by the CHRO at the public hearing stage if it concludes that a discriminatory employment practice has occurred. Currently, CHRO hearing officers are authorized by statute to award reinstatement and back-pay as forms of relief. This Section permits the CHRO to award the amount of damages suffered by the complainant, including the "actual costs incurred by the complainant" as well as "reasonable attorney's fees and costs."

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§ 9

Any employer who fails to provide the training and education concerning the illegality of sexual harassment and the remedies available to victims of sexual harassment as required by this Act, shall be fined up to $1,000 for this violation.

This Section also authorizes the executive director of the commission to assign a designated representative of the commission to enter an employer's place of business during normal business hours for the purposes of: (1) ensuring compliance with the prescribed posting requirements and (2) examining records, policies, procedures, postings and sexual harassment training materials maintained by the employer in connection with the requirements of this Act. The designated representative of the commission, who is carrying out the duties set forth in this Act, must ensure that such activities do not unduly disrupt the business operations of the employer.

§ 10

This Section expressly permits the award of punitive damages in cases of employment discrimination.

12. PUBLIC ACT 19-25. AN ACT CONCERNING PAID FAMILY AND MEDICAL LEAVE.

Please see the summary of this Act prepared by Wiggin and Dana LLP's Labor, Employment and Benefits Department, at https://www.wiggin.com/labor-employment-and-benefits/publications/connecticut-significantly-expands-coverage-of-family-and-medical-leave-act-adopts-paid-leave/.

This Act was amended by Sections 232–235 of Public Act 19-117.

Sections 232–235 of Public Act 19-117 broaden the definition of "base weekly earnings" and "subject earnings" to include self-employment income, provided that the recipient has enrolled in the Paid Family Medical Leave Insurance Program.

Section 233 of Public Act 19-117 reduces, from 15 to 13 members, the voting members of the board of directors of the Paid Family and Medical Leave Insurance Authority. It makes the Secretary of OPM and the State Treasurer, or persons designated by them to serve in their places, nonvoting members of the board.

Under current law, no member of the board or any officer, agent, or employee of the Paid Family and Medical Leave Authority may have any financial interest in any entity contracting with the Authority. Section 232 of Public Act 19-117 clarifies that "financial interest" does not

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include an interest of a *de minimis* nature or an interest that is not distinct from that of a substantial segment of the public.

Section 234 of Public Act 19-117 removes a requirement of the board of directors of the Paid Family and Medical Leave Insurance Authority to issue requests for proposals if it chooses to use outside contractors for certain services. It also provides that if the board chooses to establish additional standard criteria for the evaluation of proposals relating to claims processing, website development, database development, and marketing and advertising, the criteria must be posted on a public Internet website maintained by the Authority for notice and comment for at least one week prior to approval by the board by a two-thirds vote.

Section 235 Public Act 19-117 delays, until January 1, 2022, the creation of a "non-charge" against an employer's unemployment tax experience rate when an employer lays off an employee due to an employee's return from FMLA leave. The creation of the "non-charge" will, once in effect, allow an employer to lay off an employee who was temporarily filling the position of someone on FMLA leave without increasing the employer's unemployment taxes.

V. ACTS CONCERNING HOUSING AND REAL PROPERTY

13. PUBLIC ACT 19-51. AN ACT CONCERNING FIRE SPRINKLER SYSTEMS IN RENTAL UNITS.
Effective October 1, 2019

Current law requires all landlords to include a notice in each lease regarding the existence (or lack thereof) of a fire sprinkler system in the building. This Act narrows the requirement to landlords of buildings that are required by law to be equipped with a fire sprinkler system (i.e., those with more than (i) four floors and built for human occupancy and (ii) 12 living units and occupied primarily by elderly individuals).

The notice must be printed in at least 12-point boldface type of uniform font and should include whether there is a fire sprinkler system and the date of the system's maintenance and inspection.

14. PUBLIC ACT 19-66. AN ACT EXPANDING ELIGIBILITY FOR TAX RELIEF FOR CERTAIN ELDERLY HOMEOWNERS.
Effective October 1, 2019

Under current law, certain elderly and disabled real property owners are entitled to property tax relief under the State's Circuit Breaker Program (i.e., the Elderly and Disabled Homeowners' Tax Relief Program). This program entitles older adults and individuals with a

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permanent and total disability to a property tax reduction, which varies based on the individual's income.

This Act specifies that tax relief under this program also extends to owners of real property that is held in trust for the owner. Under this Act, to qualify for tax relief on a home that is held in trust, the owner or the owner and his or her spouse must be both the grantor and beneficiary of the trust.

15. PUBLIC ACT 19-168. AN ACT CONCERNING PUBLIC HOUSING.
Effective October 1, 2019

§ 1

Current law allows municipalities to require nonresident landlords to file their current residential addresses with the municipality's tax assessor.

This Section now allows municipalities to require vacant and occupied project-based housing providers ("PBHPs") to file their current residential addresses with the municipality's tax assessor. PBHPs are property owners who contract with the U.S. Department of Housing and Urban Development to rent to tenants under the federal Housing Choice Voucher Program. If the PBHP's owner is a business entity, then the owner may file the residential address of the agent in charge. The PBHP owner must file a change of address within 21 days after the change.

For the purposes of this Act, PBHPs must also identify and provide the residential addresses of individuals and entities that exercise day-to-day financial or operational control of the property.

§ 2

This Section doubles the maximum penalty for the first violation of the filing requirements (from $250 to $500).

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VI. ACTS CONCERNING LICENSING AND TRAINING REQUIREMENTS FOR PROFESSIONALS

16. PUBLIC ACT NO. 19-115. AN ACT CONCERNING ALZHEIMER'S DISEASE AND DEMENTIA TRAINING AND BEST PRACTICES.

§§ 1–2
Effective January 1, 2020

Under current law, a physician or APRN applying for license renewal must earn 50 contact hours of continuing medical education within the preceding two-year period. This Section requires that behavior health educational opportunities of continuing medical education include at least two contact hours of training and education on the diagnosis, treatment, and care of patients with (i) cognitive conditions such as Alzheimer's disease, dementia, delirium related cognitive impairments, and geriatric depression or (ii) mental health conditions, including, but not limited to, mental health conditions common to veterans and family members of veterans.

§ 3
Effective June 5, 2019

This Section creates a nine-member working group, established by the Commission on Women, Children and Seniors, to review recommendations of the Task Force on Alzheimer's Disease and Dementia, determine gaps in implementation of those recommendations, and make recommendations concerning best practices for Alzheimer's disease and dementia care. The nine-member working group will consist of:

- the executive director of the Commission on Women, Children and Seniors, or the executive director's designee, who will be the chairperson of the working group;
- the executive director of the Connecticut chapter of the Alzheimer's Association, or the executive director's designee;
- the Commissioner of DORS, or the commissioner's designee;
- the executive director of the Connecticut chapter of the American Association of Retired Persons, or the executive director's designee;
- the State Ombudsman, or a representative of the Office of the LTC Ombudsman;
- a family representative of a person with Alzheimer's disease;
- a family representative of a person with dementia;
- a person diagnosed with Alzheimer's disease or dementia; and
- a health care professional with expertise in the diagnosis and treatment of Alzheimer's disease and dementia.

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The working group will submit a report on its findings no later than January 30, 2020 to the Joint Committee on Aging. The working group terminates on the day it submits its report, or December 1, 2020, whichever is later.

17. PUBLIC ACT 19-164. AN ACT CONCERNING SOCIAL WORKERS.
Effective October 1, 2019

§ 1

This Section prohibits anyone from using the title "social worker," or any associated initials, or advertising services as a "social worker" unless he or she (ii) has a bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education ("CSWE"); (ii) has a doctorate in social work; or (iii) completed an education program that CSWE deems equivalent if educated outside of the U.S. or its territories. This Section exempts (i) municipal employees with the title "social worker" hired before July 1, 2019 and (ii) state employees with the title "social worker."

Finally, this Section requires the State, on any posting for a job in the social work series of classified service that does not require a social work license, to specify that the preferred qualification for employment is a bachelor's or master's degree in social work from a CSWE-accredited social work program or a doctorate in social work.

§ 2

From October 1, 2010 to October 1, 2013, a person with a master's degree in social work could operate his or her own independent practice. This Section removes this ability.

18. PUBLIC ACT 19-170. AN ACT CONCERNING INTERPRETER STANDARDS.
Effective July 1, 2019

Prior to this Act's effective date, the law required anyone receiving compensation for providing interpreting services for the deaf and hearing impaired as part of his or her job duties to register annually with DORS and hold one of several allowable credentials. This Act expands the interpretive services to include interpretation for a deaf-blind person. This Act also expands the circumstances that require interpreters to register and creates exceptions to this requirement under narrow circumstances. Under this Act, an individual must register with DORS as a qualified interpreter to: (i) interpret or offer to interpret for another person, agency, or entity; (ii) use the title "interpreter," "transliterator," or similar title in advertisements or communications or in connection with services provided under his or her name; (iii) present or identify himself or herself as an interpreter qualified to interpret in the State; or (iv) perform the function of, or convey the impression that, he or she is an interpreter or transliterator.

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The Act also revises the definition of "medical settings" for which persons providing interpretive services must be registered with DORS. Under the Act, these settings are defined as "gatherings or gathering places where health and wellness issues are addressed, including but not limited to, hospitals, clinics, assisting living and rehabilitation facilities, mental health treatment sessions, psychological evaluations, substance abuse treatment sessions, crisis intervention and appointments or other treatment requiring the presence of a doctor, nurse, medical staff or other health care professional." While nursing homes and residential care homes are not specifically mentioned, this definition is broad enough to include those settings.

This Act does exempt certain individuals from the requirement to register annually with DORS, including individuals interpreting: (i) at the request of a deaf, deaf-blind, or hard of hearing person (e.g., friends or family); (ii) at worship services conducted by religious entities; (iii) at services for educational purposes conducted by religious entities or religiously-affiliated schools; (iv) during emergency situations, if obtaining a registered interpreter or transliterator could cause delay leading to injury to or loss of the persons requiring interpretation services, provided that emergency assistance does not waive communication access requirements pursuant to the Americans with Disabilities Act or Section 504 of the Rehabilitation Act of 1973; (v) as part of a supervised internship or practicum at an accredited college or university or a DORS-approved mentorship if (a) the interpreting is not in a legal, medical, or educational setting or (b) the individual is accompanied by an interpreter who is registered with DORS; or (vi) in Connecticut for no more than 14 days during a calendar year, if certified by a national professional certifying body (i.e., National Registry for Interpreters for the Deaf or National Association of the Deaf) or a recognized state professional certifying body from outside the State.

This Act also expands the list of allowable credentials for interpreter certification to include the following credentials from the Massachusetts Commission on the Deaf and Hard of Hearing: (i) Approved Deaf Interpreter, (ii) Approved American Sign Language-English Interpreter, and (iii) Approved Sign Language Transliterator.

This Act further requires DORS to (i) maintain a current listing of registered interpreters on its website and (ii) annually issue interpreter identification cards to registered interpreters listing the type of settings where the cardholder can interpret.

In addition, this Act provides that people who are deaf, deaf-blind, or hard of hearing may request or use a different registered interpreter than the one provided in any setting in accordance with a nationally recognized interpreter code of professional conduct.

Finally, this Act authorizes anyone to report a violation of its provisions to Disability Rights Connecticut, Inc.

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VII. ACTS CONCERNING PROBATE

19. PUBLIC ACT 19-47. AN ACT CONCERNING PROBATE COURT OPERATIONS.

§§ 1, 10–15
Effective June 4, 2019

These Sections allow for the probate court administrator to maintain an electronic filing system for filing, sending, receiving, and viewing probate court documents. The system must also enable users to pay associated court fees and expenses. Under these Sections, the probate court or a party or attorney in a probate court matter can use the system to electronically serve a filing, notice, or other document to a registered user of the system if the court has granted the filer's request for online access to the matter's records. These Sections also specify that using the electronic filing system satisfies the law's requirements on transmitting a filing, notice, or document by means other than personal service.

Further, under current law, individuals may appeal a probate court order, denial, or decree within a certain time period. The length of time permitted for an appeal varies based on the matter involved. Currently, the time period for an appeal is calculated from when the court sent the order, denial, or decree. Under these Sections, the appeal period is calculated from that date or the date on which it electronically served the order, denial, or decree, whichever is later.

§ 4
Effective July 1, 2019

This Section increases, from $225 to $250, the fee for filing motions, petitions, or applications in probate court for matters other than decedents' estates.

§ 17
Effective July 1, 2019

This Section repeals a procedure by which, under current law, a petitioner may freeze the assets of someone who is the subject of a conservatorship proceeding by filing a certified copy of the petition with a financial institution or recording the copy on the land records.

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20. PUBLIC ACT 19-137. AN ACT CONCERNING ADOPTION OF THE CONNECTICUT UNIFORM TRUST CODE.
Effective January 1, 2020

Please see the summary of this Act prepared by Wiggin and Dana LLP's Private Client Services Department, at https://www.wiggin.com/private-client-services/publications/estate-planning-alert-connecticut-legislature-passes-overhaul-of-connecticut-trust-law/.

VIII. ACTS CONCERNING HEALTH PROVIDER SERVICES

21. PUBLIC ACT 19-56. AN ACT CONCERNING THE LEGISLATIVE COMMISSIONERS' RECOMMENDATIONS FOR REVISIONS TO THE PUBLIC HEALTH STATUTES, DENTAL ASSISTANTS AND DENTAL THERAPY.
Effective as noted

§ 12
Effective June 13, 2019

This Section concerns the task force that studies (i) the short-term and long-term needs of adults with intellectual disability including issues related to aging, including Alzheimer's disease, dementia and related disorders, and (ii) ways to provide services and support to such adults in need. This Section requires the task force to submit a report on its findings and recommendations to the Joint Committee on Public Health and terminate by January 1, 2020 (instead of January 1, 2019).

§ 13
Effective July 1, 2019

Current law allows a licensed dentist to delegate procedures concerning fillings, oral health education for patients, placement of dental sealants, and coronal polishing so long as these are done under the dentist's indirect supervision. This Section expands the types of procedures a licensed dentist may delegate to an expanded function dental assistant to include the administration of topical anesthetic and taking alginate impressions of teeth but requires that a licensed dentist will directly supervise and assume responsibility for the procedures.

Current law requires licensed dentists to only delegate these dental procedures to dental assistants or expanded function dental assistants who have successfully completed the Dental Assisting National Board's infection control examination. An "expanded function dental assistant" is a dental assistant who has passed the Dental Assisting National Board's certified dental assistant or certified orthodontic assistant examination and then completed (i) an expanded function dental assistant program at an institution of higher education that is

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accredited by the Commission on Dental Accreditation of the American Dental Association and (ii) a written examination administered by the Dental Assisting National Board.

This Section expands this to permit delegation to those assistants who have successfully completed an infection control competency assessment accredited by the American Dental Association's Commission on Dental Accreditation.

This Section increases the amount of on-the-job training by a licensed dentist for the purposes of preparing for an infection control examination from 9 months to 15 months.

§ 14
Effective January 1, 2020

This Section allows dental hygienists to engage in the practice of dental therapy if they (i) are a licensed by the State as a dental hygienist, (ii) obtained a dental therapist certification from an institution of higher education accredited by the Commission on Dental Accreditation, (iii) successfully completed a comprehensive examination prescribed by the Commission on Dental Competency Assessments, (iv) completed 1,000 hours of clinical training under a licensed dentist and six hours of continuing education related to dental therapy prior to entering into the first collaborative agreement, and (v) have entered into a collaborative agreement with a licensed dentist. Each dental therapist must complete six hours of continuing education in dental therapy within 12 months after entering into a collaborative agreement and each subsequent 24-month period afterwards.

This Section defines the practice of dental therapy as the performance of certain educational, preventive, and therapeutic practices and procedures. A dental therapist will practice in a public health facility under the general supervision of a licensed dentist. Public health facilities include a senior center or MRC.

A collaborative agreement is a written agreement between a dental therapist and a licensed dentist that defines their working relationship. The agreement must be signed and maintained by the parties, reviewed on an annual basis, and available for DPH inspection upon request. A dentist may not enter into a collaborative agreement with more than two dental therapists at one time and is professionally and legally responsible for all services authorized and performed by a dental therapist under the collaborative agreement.

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22. PUBLIC ACT 19-98. AN ACT CONCERNING THE SCOPE OF PRACTICE OF ADVANCED PRACTICE REGISTERED NURSES.

Effective October 1, 2019

§§ 3–4

Under current law, an employer must provide a competent physician or surgeon to attend to an injured employee and provide any medical rehabilitation and medication the physician deems reasonable or necessary. These Sections expand the law to allow an employer to provide an APRN instead of a physician or surgeon, and provide the necessary treatment deemed reasonable by the APRN.

An employee must select the physician, surgeon, or APRN that will treat his or her injury from an approved list provided by the Workers' Compensation Commission. If the employer has a full-time staff physician, surgeon, or APRN, the initial treatment required immediately after the injury may be provided by that practitioner.

These Sections allow an injured employee to select a physician or APRN from the approved list provided by the Workers' Compensation Commission at the expense of the employer if the employer fails to promptly provide one.

§ 6

Under current law, when an employer or insurer discontinues or reduces payment for Workers' Compensation claims, it must notify the employee claimant. This notice, under current law, must identify the claimant's physician. This Section expands this to permit identification to the claimant's physician or APRN.

§ 7

Under current law, contracts between a managed care company, other organization, or insurer and a medical provider such as a physician, chiropractor, naturopathic provider, podiatrist, dentist, optometrist, or psychologist are prohibited from containing an indemnification agreement for any expenses and liabilities of the managed care company, other organization, or insurer. This Section now extends the definition of a medical provider to include APRNs.

§ 8

Under current law, mental health services provided by certain health care professionals are covered and paid in the same manner as they would be if rendered by a physician or psychologist. This Section now requires mental health services rendered by an APRN to be

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covered by health insurers and paid in the same manner as those services rendered by physicians or psychologists.

Under current law, health care centers are not required to provide benefits for mental health services provided by facilities that are not affiliated with the health care center, except in the case of emergency services or when an individual is referred by a physician. This Section extends this exception to referrals made by an APRN.

§§ 9–12

Under current law, health insurance benefits cover a physician's diagnosis of significant changes in a patient's diabetes and medically necessary outpatient education and training. This Section now requires insurance benefits to cover APRNs diagnoses and outpatient education and training for a patient's diabetes.

§ 14

Under current law, when a patient is denied permission by a hospital to examine his or her medical record, the patient may file a written motion with the Superior Court to access their record. The court may order the record to be produced for examination by the patient or the patient's physician. This Section now allows for an APRN to examine the patient's record under these circumstances.

§ 15

This Section allows an APRN, if they are specified on a death certificate, to access the "administrative purposes" section of the death certificate.

§ 19

Under current law, DPH is required to annually issue a list of reportable diseases, emergency illnesses, health conditions, and reportable laboratory findings to each licensed physician and clinical laboratory in the State. This Section now requires this list to be distributed to licensed APRNs as well.

§ 20

Under current law, DPH establishes and maintains State laboratories to perform examinations of tissue samples or other laboratory tests for the diagnosis and control of preventable diseases and protection of public health. These examinations are performed upon application by a licensed physician, dentist, podiatrist, other laboratories, local directors of health, and public

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utilities or State departments or institutions. This Section now allows APRNs to submit applications for laboratory examinations at DPH State laboratories.

§ 21

Under current law, a patient's health care provider may access and examine a patient's tissue samples on a patient's behalf. This Section expands the definition of a health care provider to allow an APRN to access and examine tissue samples on a patient's behalf.

§§ 22–23

Under current law, a pharmacist may enter into a collaborative drug therapy management agreement with one or more physicians to manage the drug therapy of individual patients. A pharmacist who is part of a collaborative drug therapy agreement may be authorized to modify drug therapy prescribed to a patient but must notify the treating physician. Additionally, the pharmacist must report the patient's drug therapy management to the physician at least every thirty days. This Section now allows a collaborative drug therapy agreement between a pharmacist and an APRN.

§ 25

Under current law, disclosure of communications or records concerning a patient's mental health condition without written consent of the patient are authorized only in certain situations, such as: (i) disclosure to other persons treating the patient or another mental health facility where the patient is admitted for diagnosis and treatment, (ii) if there is a substantial risk of imminent physical injury by the patient to himself or others, (iii) when disclosure to individuals or agencies involved in collection of fees for these services is necessary to resolve a dispute over the fees or claims, (iv) if disclosure is ordered by a court, or (v) disclosure in a civil proceeding in which the patient introduces his or her mental condition as an element of a claim or defense. This Section now applies these exceptions to APRNs certified as psychiatric providers.

§ 26

This Section applies the existing statute of limitations for malpractice actions (i.e., two years from the date the injury is first sustained, discovered, or should have been discovered) against physicians or certain other providers to APRNs.

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23. PUBLIC ACT 19-113. AN ACT CONCERNING THE USE OF AUTOMATIC EXTERNAL DEFIBRILLATORS.
Effective October 1, 2019

This Act provides that any physicians, dentists, or RNs and LPNs who operate an automatic external defibrillator ("AED") to render emergency medical or professional assistance to a person in need shall be immune from liability for civil damages for personal injuries caused by the AED's malfunctioning; provided, that, the malfunctioning was not a result of such provider's negligence.

24. PUBLIC ACT 19-144. AN ACT CONCERNING A COLLABORATIVE RELATIONSHIP BETWEEN PHYSICIAN ASSISTANTS AND PHYSICIANS.
Effective July 1, 2019

This Act redefines the relationship between a PA and physician as "collaborative," rather than "dependent." Current law defines the relationship as dependent, meaning that PAs must provide care under the supervision, control, responsibility, and direction of a licensed physician.

25. PUBLIC ACT 19-149. AN ACT CONCERNING MOBILE DENTAL CLINICS.
Effective June 24, 2019

This Act requires DSS to reimburse a mobile dental clinic for dental services provided by a licensed dentist or dental hygienist to Medicaid beneficiaries within 30 miles of the associated dentist's fixed location. The reimbursable service area is a 50-mile radius for mobile dental clinics located in New London, Litchfield, and Windham counties. DSS may adopt regulations to implement this Act.

IX. MISCELLANEOUS ACTS OF INTEREST

26. PUBLIC ACT 19-57. AN ACT CONCERNING FUNERAL SERVICE CONTRACTS AND CEMETERIES.
Effective January 1, 2020

§ 1

This Act increases, from $8,000 to $10,000, the maximum allowable amount of an irrevocable funeral service contract. This Act further requires that these contracts provide that after the contract's required services are performed, the remaining funds be used to pay the State for the amount of medical assistance or other public assistance the State paid on behalf of the decedent or his or her dependent child.

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27. PUBLIC ACT 19-127. AN ACT CONCERNING THE INNOVATION INCENTIVE PROGRAM FOR NONPROFIT PROVIDERS OF HUMAN SERVICES.
Effective July 1, 2019

This Act replaces current law, which merely authorizes OPM to establish an incentive program, and requires the establishment of a pilot program to provide incentives for qualifying nonprofit human service providers that realize savings in the State-contracted services they deliver. "Nonprofit providers of human services" means nonprofit providers of services to persons with intellectual, physical, or mental disabilities or autism spectrum disorder.
Under current law, eligible providers must (i) have State contracts of $1 million or less and (ii) provide direct services to no more than 150 people enrolled in State-funded assistance programs in specific geographic regions of the State. This Act removes these criteria and instead limits eligibility to eight nonprofit human service providers with State contracts in the following amounts (two from each tier):

- $50 million or more,
- at least $20 million but less than $50 million,
- at least $5 million but less than $20 million, and
- less than $5 million.

This Act also mandates that the pilot program (i) allow participating providers to keep a portion of any savings they realize from the contracted service cost as long as they meet their contractual requirements and use 50% of the savings they retain to expand services, and (ii) prohibit future State contracts for the same type of service from being reduced solely on savings achieved under the pilot.

28. PUBLIC ACT 19-157. AN ACT CONCERNING THE DEPARTMENT ON AGING AND DISABILITY SERVICES AND MEALS ON WHEELS.
Effective July 1, 2019, except as otherwise noted

§§ 1–97
Effective October 1, 2019

The Department of Rehabilitation Services will be renamed the "Department of Aging and Disability Services." To affect this name change, these Sections replace references to DORS with references to DOADS.

§ 98

This Section allows DSS, beginning July 1, 2020, to annually increase the reimbursement rate for meals-on-wheels providers under the Connecticut Home Care Program for Elders ("CHCPE") by at least the Consumer Price Index's cost-of-living adjustment. CHCPE is a

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Medicaid waiver and State-funded program that provides a range of home- and community-based services for individuals age 65 and older who are at risk of institutionalization, and who qualify because their limited income and asset levels meet eligibility requirements.

This Section also allows DSS to further increase a Meals-on-Wheels provider's rate if the provider submits evidence of extraordinary costs related to delivering these meals in underpopulated, rural areas of the State.

§ 99

Under current law, DORS must (i) review, in consultation with Senior Resources Agency on Aging, North Central Area Agency on Aging, Agency on Aging of South Central CT, Southwestern CT Agency on Aging, and Western CT Area Agency on Aging its method for allocating federal Older Americans Act funds to the agencies for supportive services and elderly nutrition and (ii) report any findings and recommendations from its review to the Joint Committees on Appropriations and Human Services. This Section requires DORS to now also report service level and cost data to the committees and requires elderly nutrition program providers to annually provide DORS with such information.

§ 100

This Section requires DPH, as part of its quality of care program for licensed health care facilities (including nursing homes), to develop recommendations on collecting and analyzing data on patient malnutrition to improve quality of care. By law, the program must develop a standardized data set to measure health care facilities' clinical performance and require such data to be periodically collected and reported to DPH.

29. PUBLIC ACT 19-191. AN ACT ADDRESSING OPIOID USE.
Effective October 1, 2019, unless otherwise noted

§ 1

Under current law, a pharmacy is required to maintain a record, either in writing or electronically, of any prescription transmitted to it. This Section requires that prior to or simultaneous with dispensing a drug, a pharmacist must offer to discuss the drug and counsel the patient on its use, except when the person picking up the prescription is someone other than the patient or the pharmacist determined it is appropriate to make the consultation offer in writing. A written offer to the patient must include an offer to communicate either in person at the pharmacy or by telephone.

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A pharmacist is not required to provide counseling to a patient who refuses it. The pharmacist must keep a record of counseling, or any refusal by (or inability of) the patient to accept counseling. These records must be maintained for three years.

§ 3
Effective June 5, 2019

Under current law, a prescribing practitioner is required to review a patient's record in the electronic drug monitoring program prior to prescribing any controlled substance for greater than 72 hours. If a prescribing practitioner prescribes a controlled substance for continuous or prolonged treatment, the prescriber must review the patient's record at least once every 90 days. A prescribing practitioner is permitted to designate an authorized person to review the electronic drug monitoring program on their behalf prior to prescribing a controlled substance.

This Section now allows for a pharmacist to designate a pharmacy technician to access the electronic prescription drug monitoring program on behalf of the pharmacist, but only for the purposes of facilitating the pharmacist's review. A pharmacist must provide training for the authorized pharmacy technician prior to designating him or her to access the electronic prescription drug monitoring program and patients'-controlled substance prescription information. Additionally, a pharmacist must be designated as the person responsible for ensuring a pharmacy technician's access is limited to the purposes described in this Section and maintains confidentiality. The pharmacist may be subject to disciplinary action for acts of the authorized pharmacy technician.

This Section does not prohibit a prescribing practitioner from disclosing controlled substance prescription information to DSS for the purposes of administering medical assistance programs.

§ 4

Under current law, a registered manufacturer or wholesaler of drugs must have a system to identify suspicious orders of controlled substances and must immediately inform the Drug Control Division of suspicious orders. This Section now requires registered manufacturers or wholesalers of drugs that cease or decline distribution of schedule II–V controlled substances to a pharmacy or practitioner in Connecticut to report (i) the name and location of the pharmacy or practitioner and (ii) the reason for ceasing or declining distribution. This report must be provided in writing to the Drug Control Division no later than five business days after ceasing or declining distribution.

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§ 5

This Section prohibits a life insurance or annuity policy from excluding coverage solely based on the applicant receiving a prescription for naloxone or a generic equivalent opioid antagonist.

§ 6

This Section requires a practitioner who prescribes an opioid drug for the treatment of pain for a patient for greater than 12 weeks to establish a treatment agreement or discuss a care plan for chronic use of opioids. The treatment agreement or care plan must include treatment goals, risks of using opioids, urine drug screens, and expectations regarding the continuing treatment of pain with opioids, or situations requiring discontinuation of opioid treatment. The treatment agreement or care plan must be recorded in the patient's medical record.

X. ACTS CONCERNING GOVERNMENT STUDIES AND TASK FORCES

30. PUBLIC ACT 19-70. AN ACT ESTABLISHING A COUNCIL ON PROTECTING WOMEN'S HEALTH.
Effective July 1, 2019

This Act creates a 20-member Council on Protecting Women's Health to monitor federal legislation and litigation related to women's health. The council will advise the Joint Committees of Public Health and Insurance on strategies and any necessary legislative changes to ensure that the federal government does not impede the provision of health care to women in Connecticut. The council must meet at least quarterly. Starting by January 1, 2020, the council must annually submit a status report to the Joint Committees on Public Health and Insurance.

The committee will be comprised of:

- the Commissioner of DPH, or the commissioner's designee;
- the Commissioner of DMAS, or the commissioner's designee;
- the Commissioner of DOI, or the commissioner's designee;
- the executive director of OHS, or the executive director's designee;
- the Healthcare Advocate, or the advocate's designee;
- the Secretary of OPM, or the secretary's designee; and
- 14 members of the public knowledgeable on issues relating to women's health in the State.

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31. SPECIAL ACT 19-10. AN ACT ESTABLISHING A TASK FORCE TO STUDY REMEDIES AND POTENTIAL LIABILITY FOR UNREASONABLY CONTESTED OR DELAYED WORKERS' COMPENSATION CLAIMS.
Effective June 4, 2019

This Act establishes a task force to study unreasonably contested and delayed workers' compensation claims. Specifically, the task force must (i) identify the extent of unreasonably contested or delayed clams, (ii) study methods to expand remedies for such unreasonably contested or delayed claims, and (iii) clarify existing law regarding bad faith handling of such claims. This Act requires the study to include, but not be limited to an examination of: (i) how claims are handled when an injured worker is or is not covered by employee benefit health insurance, (ii) the ability of the Workers' Compensation Commission to fine insurance companies for unreasonably contesting or delaying claims, (iii) delays caused by the failure of medical professionals to follow the Professional Guide for Attorneys, Physicians and Other Health Care Practitioners Guidelines for Cooperation, and (iv) remedies available when an undue delay results in an unnecessary delay in medical treatment.

Not later than January 1, 2020, the task force must submit a report on its findings and recommendations to the Joint Committee on Labor. The task force terminates on the date it submits its report or January 1, 2020, whichever is later.

32. SPECIAL ACT 19-12. AN ACT ESTABLISHING A TASK FORCE TO INCREASE EMPLOYMENT OPPORTUNITIES FOR PERSONS WITH DISABILITIES.
Effective June 4, 2019

This Act establishes a task force to study how to increase employment opportunities for persons with disabilities. The task force will study and make recommendations about (i) expanding existing employment assistance programs for persons with disabilities and (ii) establishing financial incentives for businesses to employ more persons with disabilities.

The task force must submit a report of its findings and recommendations to the Joint Committees on Finance, Revenue and Bonding, Human Services, Labor, and Public Health. The task force will terminate either on the date that it submits the report or on February 1, 2020, whichever is later.

33. SPECIAL ACT 19-18. AN ACT CONCERNING A COMMUNITY OMBUDSMAN.
Effective June 5, 2019

This Act requires DSS and the LTC Ombudsman, who heads DORS and DSS, to jointly develop a Community Ombudsman program to investigate complaints concerning home and community-based services administered by DSS. The LTC Ombudsman and DSS must submit

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a report to the Joint Committees on Aging and Human Services by January 1, 2020, describing program logistics such as the population served, types of services offered, and the appropriations needed to staff the program.

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