

OFFICE OF LEGISLATIVE RESEARCH
PUBLIC ACT SUMMARY



PA 24-19—sSB 1
Public Health Committee
Appropriations Committee

**AN ACT CONCERNING THE HEALTH AND SAFETY OF
CONNECTICUT RESIDENTS**

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Starting January 1, 2025, allows hospitals, outpatient surgical facilities, and physician group practices to record and keep data on employee time spent requesting prior authorizations or precertifications from health carriers; permits these entities to make the data available to the Public Health Committee, upon request

SUMMARY: This act makes various changes to laws on home health care and home health aide worker safety and several other health-related matters.

EFFECTIVE DATE: Various; see below.

§ 1 — HOME HEALTH SAFETY-RELATED CLIENT INTAKE

Generally requires home health care and home health aide agencies, except for those licensed as hospice organizations, to collect certain information during client intake (on the client and the service location) and give it to the employees assigned to the client; prohibits agencies from denying services to a client solely based on this information or on the client's inability or refusal to provide it

The act generally requires home health care and home health aide agencies (home health agencies; see *Background — Home Health Agencies*), except for those licensed as hospice organizations by the Department of Public Health (DPH), to collect certain information during intake with a prospective client and give it to any employee assigned to the client. They must do so to the extent it is feasible and consistent with state and federal laws. Specifically, they must collect and give information on the following:

1. the client, including, if applicable, the client's history of violence against health care workers, domestic abuse, or substance use; a list of the client's diagnoses, including psychiatric history; whether the client's diagnoses or symptoms have been stable over time; and any information on violent acts involving the client from judicial records or any sex offender registry data concerning the client; and
2. the service location, including, if known to the agency, the municipality's crime rate, as determined by the most recent state crime annual report issued by the Department of Emergency Services and Public Protection (DESPP) (i.e., Crime in Connecticut); presence of hazardous materials (including used syringes), firearms or other weapons, or other safety hazards; and status of the location's fire alarm system.

Towards complying with the crime rate data requirement, the act further requires these agencies to annually review DESPP's report to collect related data for the locations where the agency provides services.

The act prohibits these agencies from denying services to a client solely based on the (1) collected information or (2) client's inability or refusal to give it.

EFFECTIVE DATE: October 1, 2024

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Background — Home Health Agencies

By law, both home health care and home health aide agencies must be licensed by DPH. They both provide services in the patient's home or a similar environment.

Home health care agencies must provide professional nursing services and at least one additional service (e.g., physical or speech therapy) directly and all others directly or through contracts.

Home health aide agencies provide supportive services such as assistance with personal hygiene, dressing, feeding, and incidental household tasks. These services must be provided under a registered nurse's supervision (directly or through contract), and if the nurse determines appropriate, must be provided by certain other professionals (e.g., a social worker) (CGS § 19a-490).

§ 2 — HOME HEALTH AGENCY WORKER SAFETY TRAINING AND MEDICAID REIMBURSEMENT

Requires home health agencies (except for those licensed as hospice organizations) to do monthly safety assessments with direct care staff and comply with certain workplace safety-related training requirements; conditions their Medicaid reimbursement on their compliance with the training requirement; allows DSS to give a Medicaid rate enhancement for these agencies for timely reporting of workplace violence incidents

The act requires home health agencies (except for those licensed as hospice organizations) to do monthly safety assessments with direct care staff at the agency's monthly staff meeting.

It also requires them to adopt and implement a home care worker health and safety training curriculum consistent with the one endorsed by the federal (1) Centers for Disease Control and Prevention's (CDC) National Institute for Occupational Safety and Health and (2) Occupational Safety and Health Administration, including training to recognize and manage common home care workplace hazards and practical ways to manage risks and improve safety. These home health agencies must provide annual staff training that aligns with this curriculum.

Under the act, the Department of Social Services (DSS) commissioner must generally require these agencies to provide evidence that they adopted and implemented the above training curriculum to continue receiving Medicaid reimbursements. The act allows the commissioner, at her discretion, to approve alternative applicable workplace training programs.

It also authorizes the commissioner to increase Medicaid rates for these agencies that report workplace violence incidents to DSS and DPH in a timely way (i.e., within seven calendar days after they happen).

EFFECTIVE DATE: October 1, 2024

§ 3 — HOME HEALTH REPORTING OF CLIENT THREATS OR ABUSE

Requires home health agencies (except for those licensed as hospice organizations) to report to DPH on a client's verbal threats, abuse, or similar incidents, and DPH to annually report on this information

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Starting by January 1, 2025, the act requires home health agencies, except for those licensed as hospice organizations, to annually report to DPH, in a way the department sets, on each instance of a client's verbal abuse that an agency's staff member perceives as a threat or danger, physical or sexual abuse, or any other client abuse of a staff member. The agencies also must report on the actions they took to ensure the affected staff member's safety.

Starting by March 1, 2025, DPH must annually report to the Public Health Committee on the number of reported incidents and what steps were taken to ensure the affected staff member's safety.

EFFECTIVE DATE: October 1, 2024

§ 4 — HOME HEALTH STAFF SAFETY GRANT PROGRAM

Requires DSS to create a grant program for home health agencies to provide safety escorts and purchase technology for staff safety checks

The act requires the DSS commissioner, by January 1, 2025, to establish a program giving incentive grants, on or before January 1, 2027, for home health agencies to provide (1) safety escorts for staff conducting home visits and (2) ways for staff to perform safety checks.

The latter may include a (1) mobile application that allows staff to access safety information relating to a client (including the information collected under the act, see § 1) and a way to communicate with local police or other staff in a safety emergency or (2) GPS-enabled wearable device that allows staff to contact local police by pressing a button or through another means.

Under the act, the commissioner must establish the program's eligibility requirements, priority categories, funding limitations, and application process. By January 1, 2026, and again by January 1, 2027, she must report on the program to the Public Health Committee. Specifically, she must report on (1) the number of agencies that applied for and received a grant, (2) how they used the grants, and (3) anything else she considers pertinent.

EFFECTIVE DATE: Upon passage

§ 5 — HEALTH CARE FACILITY WORKER SAFETY TRAINING AND MEDICAID REIMBURSEMENT

Requires certain health care facilities (e.g., hospitals and nursing homes) to adopt and implement certain workplace violence prevention standards; allows DSS to require evidence of compliance as a condition of Medicaid reimbursement

The act requires certain health care facilities that participate in Medicaid to adopt and implement workplace violence prevention standards consistent with those set by The Joint Commission (an independent, nonprofit organization that accredits and certifies hospitals and other health care organizations) or other applicable certification or accreditation agencies.

Under the act, the DSS commissioner may require these facilities to provide evidence that they adopted and implemented the above standards to continue

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receiving Medicaid reimbursements.

These provisions apply to DPH-licensed hospitals, chronic disease hospitals, nursing homes, behavioral health facilities, multicare institutions, and psychiatric residential treatment facilities.

EFFECTIVE DATE: October 1, 2024

§§ 6, 8, 9, 28 & 29 — WORKING GROUPS

Requires the Public Health Committee chairpersons to convene working groups on (1) staff safety issues for home health agencies and hospice organizations, (2) nonalcoholic fatty liver disease, (3) health issues for nail salon workers, (4) loneliness and isolation, and (5) pediatric hospice services

The act requires the Public Health Committee chairpersons to establish five working groups to study the following topics: (1) staff safety issues for home health agencies and hospice organizations; (2) nonalcoholic fatty liver disease, including nonalcoholic fatty liver and nonalcoholic steatohepatitis; (3) health issues faced by nail salon workers due to their occupational exposure to health hazards; (4) ways to address loneliness and isolation; and (5) pediatric hospice services.

For each of these working groups, the (1) Public Health Committee chairpersons must schedule or convene the group's first meeting, to be held by 60 days after the act's passage; (2) group must select two co-chairpersons from among its members; and (3) Public Health Committee's administrative staff serves in that capacity for the working group.

For each of these groups, other than the one on pediatric hospice services, the group (1) must report its findings and recommendations to the committee by January 1, 2025, and (2) terminates when it submits the report or on January 1, 2025, whichever is later. The pediatric hospice services working group must report to the committee by March 1, 2025.

EFFECTIVE DATE: Upon passage

Home Health and Hospice Staff Safety Working Group (§ 6)

Under the act, this working group must study staff safety issues affecting home health agencies and hospice organizations. The group must at least include three employees of one or more home health agencies and three employees of one or more hospice care organizations, including in each case at least one direct care worker; two representatives of a home health agency and two from an in-state nurses association; and one representative each from the following:

1. a collective bargaining unit representing home health employees,
2. a collective bargaining unit representing hospice care organizations or employees,
3. a mobile crisis response services provider,
4. an assertive community treatment team,
5. a police department,
6. an in-state hospital association,
7. an in-state home health agency association,

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8. the State Police, and
9. an in-state municipal police department.

The group must also include at least (1) one member of an in-state labor union; (2) the commissioners of mental health and addiction services (DMHAS), correction, DPH, and DSS, or their designees; (3) one member or employee of the Board of Pardons and Paroles; and (4) one member of the judiciary.

Nonalcoholic Fatty Liver Disease Working Group (§ 8)

This group's study must at least examine the following in relation to nonalcoholic fatty liver disease:

1. the incidence in Connecticut compared to the entire United States;
2. the population groups most affected and at risk of being diagnosed with it and the main risk factors contributing to this prevalence;
3. strategies to prevent the disease in high-risk populations and how to implement them statewide;
4. ways to increase public awareness about the disease, including public awareness campaigns about liver health;
5. whether to recommend a statewide screening program for at-risk populations;
6. policy changes needed to improve patient care and outcomes;
7. insurance coverage and affordability issues affecting treatment access;
8. creating patient advocacy and support networks; and
9. how social determinants of health influence the disease's risk and outcomes, and needed interventions to address them.

The working group must include at least the following members:

1. a physician with expertise in hepatology and gastroenterology, representing an in-state higher education institution;
2. three people in the state living with nonalcoholic fatty liver disease;
3. a representative of an in-state patient advocacy organization;
4. a social worker with experience working with communities in the state's underserved areas and addressing social determinants of health;
5. an in-state health care policy expert with experience advising on regulatory frameworks, health care access, and insurance issues;
6. an in-state nutritionist and dietician with experience giving guidance on preventative measures and dietary interventions for the disease;
7. a community health worker who works directly with the state's underserved communities addressing social determinants of health;
8. a representative of an in-state nonprofit organization focused on liver health; and
9. the DPH commissioner or her designee.

Nail Salon Worker Health Hazards Working Group (§ 9)

The act requires this group to study health issues experienced by nail salon workers due to their exposure to health hazards at work. The study must at least

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include (1) identifying these hazards, (2) ways to reduce nail salon workers' exposure to them, (3) best practices for preventing these workers from acquiring health issues from exposure to these hazards, and (4) assessing the strengths of other states' policies on protecting nail salon workers' health.

The working group must include at least the following members:

1. three nail technicians, each employed by a different in-state nail salon;
2. three owners or managers of different in-state nail salons;
3. a state-licensed health care professional with experience treating patients for illnesses attributable to their exposure to health hazards while working in a nail salon;
4. a representative of an in-state labor union;
5. an expert in occupational safety;
6. an expert in environmental health;
7. a director of an in-state municipal health department with at least four nail salons under the department's jurisdiction; and
8. the DPH commissioner or her designee.

Loneliness and Isolation Working Group (§ 28)

Under the act, this group must study and make recommendations on ways to address loneliness and isolation experienced by people in the state and to improve their social connection, including through the creation of a pilot program that uses technology to combat loneliness and foster social engagement. The working group must do the following in relation to people in the state:

1. evaluate the causes of, and other factors contributing to, this sense of isolation and loneliness, and ways to prevent and eliminate it;
2. recommend local activities, systems, and structures to combat isolation and loneliness, including opportunities for organizing or enhancing in-person community gatherings, especially for people who have lived in isolation for a long time; and
3. explore the possibility of creating municipal-based social connection committees to address the challenges of, and potential solutions for, combating isolation and loneliness.

The working group must include at least the following members, all from in-state organizations or working in the state, as applicable, unless otherwise specified:

1. a high school teacher;
2. two representatives of an alliance of private and public entities that recognize the importance of, and need for, addressing loneliness and social disconnectedness among residents of all ages;
3. a dining hall manager of a suburban soup kitchen;
4. three high school students, including one who identifies as a member of the LGBTQ+ community, one who identifies as female, and one who identifies as male;
5. two students from higher education institutions, one each from a public health school and a social work school;
6. two residents of assisted living facilities, one at a facility for veterans and

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- one at a suburban facility;
7. a member of a senior center's administration;
 8. two librarians, one each from an urban library and a rural library;
 9. a representative of an organization serving children in an urban area;
 10. a representative of an organization representing municipalities;
 11. a representative of an organization representing small towns;
 12. a representative of an organization working on policies to improve planning and zoning laws to create an inclusive society and improve access to transit-oriented development;
 13. a representative of an organization working to improve and create more walkable and accessible main streets;
 14. a representative of an organization advocating for people with physical disabilities;
 15. an expert (not necessarily from Connecticut) in digital health and identifying safe digital education;
 16. a representative of an organization developing mobile applications intended to address loneliness and isolation;
 17. a representative of an organization (not necessarily from Connecticut) that is exploring the use of technology to address loneliness and isolation;
 18. two psychiatrists, one who treats adolescents and one who treats adults;
 19. a social worker who practices in an urban area; and
 20. the DMHAS and Department of Children and Families (DCF) commissioners or their designees.

Pediatric Hospice Working Group (§ 29)

Under the act, this group must examine hospice services for pediatric patients across the state. Specifically, the group must (1) review existing hospice services for these patients, (2) make recommendations for appropriate levels of hospice services for them, and (3) evaluate payment and funding options for this care.

The working group must include at least the following members:

1. at least one representative of each in-state pediatric hospice association;
2. one representative of each DPH-licensed hospice organization;
3. at least one representative of an in-state hospital association;
4. one representative each of two in-state children's hospitals;
5. a pediatric oncologist;
6. a pediatric intensivist (i.e., a doctor who has training and experience treating seriously ill children);
7. the Public Health Committee chairpersons and ranking members; and
8. the DPH and DSS commissioners or their designees.

§ 7 — GUN SAFETY EDUCATIONAL MATERIAL DURING PRIMARY CARE VISITS

Requires DPH, in consultation with certain entities, to develop or obtain educational material on gun safety practices for primary care providers to give their patients; requires these providers to

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make this material available to patients annually, or at each appointment if the patient has less frequent visits

The act requires the DPH commissioner, by January 1, 2025, to develop or obtain educational material on gun safety practices for primary care providers to give to patients during appointments. In doing so, the commissioner must consult with the Commission on Community Gun Violence Intervention and Prevention and, if these organizations agree to this consultation, the state chapters of national professional associations of physicians, pediatricians, advanced practice registered nurses (APRNs), and physician assistants (PAs). By February 1, 2025, DPH must (1) make this material available, for free, to all in-state primary care providers and (2) recommend how they can effectively use it.

The act requires primary care providers to make this material available to each of their patients annually at their appointments, or at each appointment if the patient visits the provider less frequently than once a year.

Under the act, “primary care providers” are DPH-licensed physicians, APRNs, and PAs, regardless of board certification, who provide services in family medicine, general pediatrics, primary care, internal medicine, or primary care obstetrics or gynecology.

EFFECTIVE DATE: July 1, 2024

§ 10 — PRESCRIPTION DRUG SHORTAGE STUDY

Requires the DCP commissioner, in collaboration with UConn’s pharmacy school, to study prescription drug shortages and report on the study and any legislative recommendations to alleviate or prevent the shortages

The act requires the Department of Consumer Protection (DCP) commissioner, in collaboration with UConn’s School of Pharmacy, to study incidences of prescription drug shortages in the state and whether the state has a role to play in alleviating them. By January 1, 2025, the commissioner must report to the General Law and Public Health committees on the study and any legislative recommendations to help alleviate or prevent these shortages.

EFFECTIVE DATE: Upon passage

§§ 11-13 — LIMITATIONS ON MAINTENANCE OF CERTIFICATION

Specifically prohibits hospitals from requiring a board-certified physician to participate in an MOC program in order to obtain or keep privileges; prohibits certain health carriers and professional liability insurers from taking certain actions based on a provider’s non-participation in an MOC program or other decision to not maintain a specialty certification, unless the provider holds himself or herself out to be a specialist under the certification

Hospital Credentialing (§ 11)

Existing law prohibits hospitals (including their medical review committees) from requiring board-certified physicians to provide credentials of board recertification to obtain or keep their practice privileges. Under the act, this

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prohibition specifically includes the hospital requiring these physicians to participate in any maintenance of certification (MOC) program required for board recertification.

Insurer Reimbursement, Provider Networks, and Liability Insurance (§§ 12 & 13)

The act generally prohibits certain health carriers from denying reimbursement to a health care provider, or excluding a provider from a network, only because the provider is not maintaining a specialty certification, including through an MOC program.

It also generally prohibits professional liability insurers from (1) denying coverage to a health care provider only because the provider is not maintaining a specialty certification, including through an MOC program, or (2) requiring a provider to show evidence of maintaining a specialty certification as a condition of getting professional liability insurance or other malpractice coverage.

For either type of insurer, these provisions apply as long as the provider does not hold himself or herself out as a specialist under a specialty certification.

For purposes of these insurance provisions, “maintenance of certification” is any process requiring periodic recertification examinations or other professional development activities to maintain specialty certification. A “specialty certification” is any certification by a medical board that specializes in one area of medicine and has requirements in addition to state licensing requirements.

The act’s health carrier provisions apply to insurers and other entities that deliver, issue, renew, amend, or continue individual or group policies in the state on or after January 1, 2025, that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan.

The act’s liability insurer provisions apply to insurance companies that deliver, issue, renew, amend, or continue professional liability insurance policies in the state on or after January 1, 2025.

EFFECTIVE DATE: Upon passage, except the insurer-related provisions take effect January 1, 2025.

§§ 14-16 — OPIOID DEACTIVATION AND DISPOSAL SYSTEMS

Generally allows pharmacists, when dispensing opioids, to give the patient information on personal opioid drug deactivation and disposal systems, including information that DMHAS must post on its website; requires DMHAS and certain other people and entities to study long-term payment options for these systems

The act requires the DMHAS commissioner, by October 1, 2024, to post information on the department’s website about personal opioid drug deactivation and disposal systems. Under the act, these systems are products designed for personal use that allow patients to permanently deactivate and destroy opioids.

The act generally allows pharmacists, when dispensing opioids, to also give the patient information on these systems, including the DMHAS website address. But this does not apply to pharmacists dispensing opioids for patients who are in a

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facility or health care setting.

The act also requires the DMHAS commissioner, in collaboration with the DCP, DPH, and insurance commissioners and the Governor's Prevention Partnership, to study long-term payment options for dispensing these deactivation and disposal systems to patients, including when they are dispensed an opioid. By January 1, 2025, the DMHAS commissioner must report on the study to the General Law and Public Health committees.

EFFECTIVE DATE: Upon passage, except the pharmacist provisions take effect October 1, 2024.

§ 17 — PHYSICIANS AND PHYSICIAN ASSISTANTS UNDER THE STATE LABOR RELATIONS ACT

Removes an exemption from the state Labor Relations Act for physicians and PAs who work at DPH-licensed institutions

The act removes a prior exemption from the state Labor Relations Act for physicians or PAs who are employed by a DPH-licensed private sector institution. It appears that in removing this exemption, the act allows these providers to unionize in certain limited situations when they could not under prior law.

The state Labor Relations Act, which sets rules on unionization and related matters, generally covers private-sector employers who are (1) not subject to the National Labor Relations Act (NLRA) or (2) subject to the NLRA but the National Labor Relations Board has declined to assert jurisdiction. Generally, as with most other private sector employees, physicians and PAs are covered by the NLRA if they are directly employed by their employer and are not "supervisors." In practice, physicians are sometimes, but not always, considered supervisors for purposes of the NLRA.

Unlike the NLRA, the state Labor Relations Act includes "supervisors" within its general definition of employee.

EFFECTIVE DATE: October 1, 2024

§§ 18 & 19 — INSURANCE COVERAGE OF CORONARY CALCIUM SCANS

Requires certain insurance policies to cover coronary calcium scans

The act requires certain health insurance policies to cover coronary calcium scans. Under the act, these are CT scans of the heart looking for calcium deposits in arteries.

The act applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2025, that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

The act also applies these requirements to high deductible health plans

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(HDHPs) to the maximum extent permitted by federal law. If the HDHP is used to establish a health savings or similar account, the act applies to the maximum extent permitted by federal law that does not affect the account's tax preferred status.

EFFECTIVE DATE: January 1, 2025

§ 20 — CYBERSECURITY DISRUPTION AUDITS

Generally requires hospitals to have their cybersecurity disruption plans audited annually and make related information available to certain agencies on a confidential basis

The act requires hospitals, except for those operated exclusively by the state, to take certain actions annually, starting by January 1, 2025, in relation to their plans and processes to respond to a cybersecurity disruption of their operations. Specifically, they must:

1. submit their plans and processes to an audit (see below) to determine their adequacy and any necessary improvements; and
2. on a confidential basis, make available for inspection to DPH, the Department of Administrative Services, and DESPP's Division of Emergency Management and Homeland Security information on whether the audit found their plans and processes adequate and the steps they are taking to implement any recommended improvements.

The audit must be done by an independent, certified cybersecurity auditor or expert credentialed by the Information Systems Audit and Control Association or a similar credentialing entity.

Under the act, any recipient of the information submitted or made available under these provisions must keep the maximum level of confidentiality allowed under law and not disclose it except as expressly required by law. The information is exempt from disclosure under the Freedom of Information Act (FOIA).

EFFECTIVE DATE: Upon passage

§§ 21-23 — STATEWIDE HEALTH INFORMATION EXCHANGE

Sets a deadline for health care providers to connect to and actively participate in the Statewide Health Information Exchange ("Connie"), but exempts providers from connecting to the exchange under certain conditions; specifies (1) when providers are or are not liable for certain actions related to data security and (2) circumstances under which providers are not required to share information with the exchange; specifies that the exchange's goals must be in line with federal regulations on information blocking; requires OHS to establish a working group to make recommendations on the office's regulations, policies, and procedures related to participation in the exchange

Under existing law, within two years after the launch of the Statewide Health Information Exchange (i.e., by May 3, 2023), each licensed health care provider (including entities) with an electronic health record system capable of connecting to and participating in the exchange must apply to begin the process to do so. (The deadline was earlier for hospitals and clinical laboratories.) For providers without such a system, the law requires that they be capable of sending and receiving secure messages in line with specified federal standards.

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The act generally requires health care providers, no later than 18 months after the Office of Health Strategy (OHS) implements policies and procedures related to exchange participation, to be connected to and actively participating in the exchange. For this purpose, (1) “connection” includes onboarding with the exchange and (2) “participation” is the active sharing of medical records with the exchange under applicable law, including the federal Health Insurance Portability and Accountability Act (HIPAA) and federal regulations on the confidentiality of substance use disorder patient records. The act also requires the OHS executive director to create a working group related to these policies and procedures (see below).

But the act exempts health care providers from the requirement to connect with the exchange if they (1) have no patient medical records or (2) are individuals and exclusively practice as employees of a covered entity under HIPAA, and the covered entity is legally responsible for decisions on the safeguarding, release, or exchange of health information and medical records. In the latter case, the act specifies that the covered entity is responsible for complying with the exchange-related requirements under existing law and the act.

The act also specifies that the exchange-related provisions under existing law and the act do not require providers to share patient information with the exchange if (1) doing so is prohibited by state or federal privacy and security laws or (2) the patient’s affirmative consent is legally required and has not been obtained.

The act specifies that health care providers are not liable for any private or public claim related directly to a data breach, ransomware, or hacking experienced by the exchange. But they are liable for any failure to comply with applicable state and federal data privacy and security laws and regulations in sharing information with and connecting to the exchange. The act specifically exempts providers from the requirement to share information with or connect to the exchange if doing so would violate any other law.

Under existing law, one of the exchange’s goals is to provide patients with secure electronic access to their health information. The act specifies that this must be done in line with federal regulations on information blocking (i.e., practices that are likely to interfere with access, exchange, or use of electronic health information, unless required by law or covered by an exception; see *Background — Information Blocking*).

EFFECTIVE DATE: July 1, 2024, except the working group provisions take effect upon passage.

Working Group (§ 23)

By law, OHS must adopt regulations to implement the law’s provisions on participation in the Statewide Health Information Exchange. The executive director may adopt policies and procedures while in the process of adopting regulations.

The act requires the OHS executive director, by September 1, 2025, to establish a working group to make recommendations to the office on the parameters of these regulations and policies and procedures. (PA 24-68, § 63, moves up this date to September 1, 2024.) The recommendations must at least address (1) privacy of

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protected health care information, (2) cybersecurity, (3) health care provider liability, (4) any contract required for providers to participate in the exchange, and (5) any statutory changes that may be necessary to address any of the working group's concerns.

Under the act, the working group consists of up to 15 members, including (1) the OHS executive director or her designee, who is the working group's chairperson; (2) the state's Health Information Technology Officer or the officer's designee; (3) the Public Health Committee chairpersons and ranking members; and (4) representatives of in-state health care provider associations, which may include associations representing hospitals, ambulatory surgical centers, physicians, women's health care providers, behavioral and mental health care providers, providers for the aging, gender affirming care providers, patient advocates, and health care payers.

The act requires the OHS executive director to report to the Public Health Committee by January 1, 2025, on the working group's recommendations.

Background — Information Blocking

Federal restrictions on health information blocking apply to health care providers, health information technology (IT) developers of certified health IT, and health information exchanges or health information networks. For providers, the restrictions apply when they know that a practice is unreasonable and likely to interfere with the access, exchange, or use of electronic health information. For these other entities, the restrictions apply when they know, or should know, that a practice is likely to interfere (45 C.F.R. Part 171).

Background — Related Act

PA 24-81, §§ 90 & 176-232, renames the title of OHS's head as a "commissioner" rather than an "executive director" and makes numerous conforming changes.

§ 24 — STATE HEALTH INFORMATION TECHNOLOGY ADVISORY COUNCIL

Adds the attorney general or his designee to the State Health Information Technology Advisory Council

The act adds the attorney general or his designee to the State Health Information Technology Advisory Council. By law, the council advises the OHS executive director and state's health IT officer on, among other things, developing priorities and policy recommendations for advancing the state's health IT and health information exchange efforts.

EFFECTIVE DATE: July 1, 2024

§ 25 — HEALTHY BRAIN INITIATIVE

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Requires DPH, within available appropriations, to annually report to the Public Health Committee on its work on the CDC's Healthy Brain Initiative

The act requires DPH, within available appropriations and starting by January 1, 2025, to annually report to the Public Health Committee on the department's work on the Healthy Brain Initiative. Under the act, this initiative is the CDC's collaborative approach to fully integrate cognitive health into public health practice and reduce the risk and impact of Alzheimer's disease and other dementias.

EFFECTIVE DATE: Upon passage

§ 26 — PARKINSON'S DISEASE REGISTRY

Requires (1) DPH, within available appropriations and in collaboration with an in-state public college or university, to maintain and operate a Parkinson's disease registry and (2) hospitals and certain health care providers to submit data to the registry as DPH requires, subject to patients opting out; establishes a data oversight committee to monitor the registry's activities

The act requires DPH, by April 1, 2026, and within available appropriations, to maintain and operate a statewide data registry on Parkinson's disease and Parkinsonism (which generally refers to a range of symptoms associated with Parkinson's disease and certain other conditions). DPH must do so in collaboration with an in-state public higher education institution. Hospitals, physicians, PAs, and nurses must make data on patients admitted to the hospital or treated by these providers for these conditions available to the registry as required by DPH regulations. Hospitals and these providers must give patients a notice about these disclosures to the registry and an opportunity to opt out.

DPH and authorized researchers can use the registry data, but they must keep confidential any personally identifiable patient information (i.e., not subject to disclosure or admissible as evidence in a court or agency proceeding, and used only for medical or scientific research). The act exempts registry data from disclosure under FOIA.

Under the act, hospitals must give DPH access to their records, as the department deems necessary, to perform case findings or other quality improvement audits to ensure the completeness of the registry reporting and data accuracy.

The act allows the commissioner to contract with an in-state nonprofit Parkinson's disease and Parkinsonism association to implement and administer the registry. She may also enter into (1) a contract for receiving, storing, and maintaining the registry data and (2) reciprocal reporting agreements with other states to exchange Parkinson's disease and Parkinsonism data.

Additionally, the act requires DPH to establish a Parkinson's disease and Parkinsonism data oversight committee. The committee must (1) monitor the registry's operation, (2) give advice on its oversight, (3) develop a plan to improve the quality of Parkinson's disease and Parkinsonism care and address any disparities in this care, and (4) develop short- and long-term goals for improving care.

The act authorizes the DPH commissioner to adopt regulations to implement

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these provisions. She may also implement policies and procedures while in the process of adopting the regulations, as long as she posts her intent to adopt regulations in the eRegulations System within 20 days after adopting the policies and procedures. The policies and procedures are valid until the final regulations are adopted.

EFFECTIVE DATE: Upon passage

Data Oversight Committee

Under the act, the DPH commissioner must appoint at least 16 members to the committee, including a:

1. neurologist;
2. movement disorder specialist;
3. primary care provider;
4. neuropsychiatrist who treats Parkinson's disease;
5. patient living with the disease;
6. public health professional;
7. population health researcher with experience in statewide health condition data registries;
8. patient advocate;
9. family caregiver of someone with Parkinson's disease;
10. representative of a Parkinson's disease-related nonprofit organization;
11. physical therapist, speech therapist, and social worker and an occupational therapist, all with experience working with people with the disease;
12. geriatric specialist; and
13. palliative care specialist.

The commissioner must make her appointments by April 1, 2026, and members serve two-year terms. She must appoint a committee chairperson from among the members, and the chairperson must schedule the committee's first meeting by April 1, 2026.

The act requires DPH to assist the committee in its work and provide any data or information the committee deems necessary to fulfill its duties, unless state or federal law prohibits the disclosure.

The committee's chairperson, starting by January 1, 2027, must annually report to the Public Health Committee and DPH commissioner on the committee's work.

§ 27 — RECENT-ONSET SCHIZOPHRENIA SPECTRUM DISORDER

Requires DMHAS, within available appropriations and in consultation with DCF, to create a program providing specialized treatment for people with recent-onset schizophrenia spectrum disorder

The act requires the DMHAS commissioner, within available appropriations and in consultation with the DCF commissioner, to establish a program for people diagnosed with recent-onset schizophrenia spectrum disorder.

The DMHAS commissioner, starting by January 1, 2025, must annually report to the Public Health Committee on (1) the functions and outcomes of the program

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for specialized treatment early in psychosis and (2) any legislative recommendations to address the needs of people diagnosed with recent-onset schizophrenic spectrum disorders.

EFFECTIVE DATE: Upon passage

Program Components

Under the act, the program must provide specialized treatment for these people early in their psychosis. It also must serve as a hub for distributing information statewide on best practices for providing early intervention services.

The program must address the limited knowledge of this disorder with regard to its region-specific treatment needs and disparities, and the prevalence of first-episode psychosis in people diagnosed with it. It also must address the funding and reimbursement for available early intervention services and the uncertainty of clinicians' availability and readiness to implement those services for patients and their families.

Under the act, the program must do the following:

1. develop structured curricula, online resources, and videoconferencing-based case conferences to distribute information for the development of knowledge and skills relevant to patients with first-episode psychosis and their families;
2. assess and improve the quality of early intervention services available to people diagnosed with a recent-onset schizophrenic spectrum disorder across the state;
3. provide expert input on complex cases and launch a referral system for consultation with experts in treating these disorders;
4. share lessons and resources from any campaigns aimed at reducing the duration of untreated psychosis to improve local pathways to care;
5. serve as an incubator for new evidence-based treatment approaches and pilot them across the state;
6. advocate for policies on the financing, regulation, and provision of services for people with these disorders; and
7. collaborate with state agencies to improve outcomes for people diagnosed with first-episode psychosis in areas such as crisis and employment services.

§ 30 — PEDIATRIC HOSPICE CARE

Requires licensed hospices to encourage their nursing staff to spend three weeks each in a pediatric intensive care unit, pediatric oncology unit, and pediatric hospice facility to enhance pediatric care skills and expertise and prepare them for future roles in pediatric hospice care

The act requires licensed hospices to encourage their nursing staff to spend three weeks each in a pediatric intensive care unit, pediatric oncology unit, and pediatric hospice facility to (1) enhance their skills and expertise in pediatric care and (2) prepare them for future roles in pediatric hospice care. The hospices must do this by July 1, 2025, and when hiring new nursing staff.

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EFFECTIVE DATE: Upon passage

§ 31 — MINIMUM NURSING HOME STAFFING LEVELS

Establishes a statutory definition of “direct care” for purposes of minimum nursing home staffing levels

Existing law requires DPH to set minimum staffing levels in nursing homes of at least three hours of direct care per resident per day. The act specifies that “direct care” is hands-on care from registered nurses, licensed practical nurses, and nurse’s aides, including help with feeding, bathing, toileting, dressing, lifting, and moving; administering medication; promoting socialization; and personal care services. It does not include food preparation, housekeeping, laundry services, maintaining the nursing home’s physical environment, or performing administrative tasks.

EFFECTIVE DATE: Upon passage

§§ 32 & 33 — CLINICAL PEERS

Generally increases the requirements to qualify as a clinical peer for insurance adverse determination reviews; requires health carriers to authorize clinical peers to reverse initial adverse determinations that were based on medical necessity

Under existing law, clinical peers doing adverse determination reviews (see *Background — Insurance Reviews*) generally must have a nonrestricted license (in any U.S. state) in the same or similar specialty that typically manages the medical condition, procedure, or treatment under review. Starting in 2026, the act instead generally requires these clinical peers to have a nonrestricted license in the same specialty as the treating physician or other health care professional who is managing the condition, procedure, or treatment under review.

By law, unchanged by the act, for urgent care requests of substance use or mental health disorders under certain circumstances, the clinical peer must be a (1) psychologist with relevant training and clinical experience or (2) psychiatrist.

The act also requires health carriers to authorize clinical peers to reverse initial adverse determinations that were based on medical necessity. This applies when the carrier, as required by law, offers a covered person’s health care professional the opportunity to confer with a clinical peer of the carrier following the adverse determination (see *Background — Conference With Clinical Peer Following Adverse Determination*).

EFFECTIVE DATE: January 1, 2025, except the change to the clinical peer definition takes effect January 1, 2026.

Background — Insurance Reviews

Generally, insurance reviews have up to three steps: (1) an initial utilization review to determine if the procedure is covered; (2) a grievance review (i.e., internal review), which occurs when a covered person appeals a benefit denial (i.e., adverse determination); and (3) an external review, which is done when a covered person

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exhausts a health carrier's internal process and appeals the carrier's adverse determination to the Insurance Department. External reviews, also called final adverse determination reviews, are done by an independent review organization assigned by the department.

Background — Conference With Clinical Peer Following Adverse Determination

The law requires a carrier to offer a covered person's health care professional an opportunity to confer with a clinical peer of the carrier under certain circumstances. This applies:

1. after a covered person or his or her representative or health care professional is notified of an initial adverse determination of a concurrent or prospective utilization review, or of a benefit request, that was at least partially based on medical necessity and
2. as long as the covered person, representative, or health care professional has not already filed a grievance of the initial adverse determination.

§§ 34 & 35 — PRIOR AUTHORIZATION FOR AMBULANCE SERVICES PROHIBITED

Prohibits health carriers from (1) requiring an enrollee to get prior authorization for a medically necessary ambulance transport to a hospital and (2) denying payment to an ambulance provider on the basis that the enrollee did not get prior authorization

The act prohibits certain health insurance policies from requiring an enrollee to get approval from the health carrier (e.g., insurer or HMO) before being transported to a hospital by ambulance when medically necessary. By law, health carriers already cannot require an enrollee to get prior authorization for calling 9-1-1 in a life- or limb-threatening emergency.

The act also prohibits a health carrier from denying payment to an ambulance provider responding to a 9-1-1 call because the enrollee did not get prior authorization for the call or the ambulance transport to a hospital.

The act applies to individual and group health insurance policies delivered, issued, or renewed in the state on or after January 1, 2025, that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; (4) accidents only; (5) limited benefits; or (6) hospital or medical services, including those provided under an HMO plan. Because of ERISA, state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2025

§ 36 — PEER-RUN RESPITE CENTER

Requires the DMHAS commissioner, within available appropriations, to establish a peer-run respite center, run by a contracted non-profit, to provide peer respite and support services to adults experiencing distress right before or during a mental health crisis

The act requires the DMHAS commissioner, within available appropriations, to

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establish a peer-run respite center, and contract with a nonprofit peer-run organization to operate it.

Under the act, the respite center must employ specialists with relevant experience and training to provide peer respite and support services for adults experiencing emotional or mental distress right before or during a mental health crisis. Generally, “peer respite services” are trauma-informed, short-term services focused on recovery, resiliency, and wellness. Among other things, “peer support services” promote engagement, socialization, recovery, and self-sufficiency.

The act requires the DMHAS commissioner, by October 1, 2025, to report on the center and related issues.

EFFECTIVE DATE: October 1, 2024

Peer-Run Respite Center

The act requires the peer-run respite center to be operated by a peer-run organization in a safe physical space. The center must employ peer support specialists with a psychiatric history or who have experienced comparable life-interrupting challenges. The specialists must have (1) experience in providing peer respite and support services and (2) completed training specified by the DMHAS commissioner.

Under the act, “peer respite services” are voluntary, trauma-informed, short-term services provided in a home-like environment that are the least restrictive of individual freedom, culturally competent, and focus on recovery, resiliency, and wellness. “Peer support services” means assistance that promotes engagement, socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and identification of personal strengths.

Under the act, the peer-run respite center must be operated by a nonprofit peer-run organization that (1) is controlled and operated by people who have psychiatric histories or experienced similar life-interrupting challenges and (2) provides a place for support and advocacy for people experiencing similar challenges.

DMHAS Report

The act requires the DMHAS commissioner, by October 1, 2025, to report to the Public Health Committee and also post the report on the department’s website.

The report must identify barriers to implementing the peer-run respite center, if any, and recommend ways to address them. It also must share data on the center’s outcomes and effectiveness, and based on that data, make recommendations on establishing more of these centers in the state, including those managed, operated, and controlled by members of certain communities who have psychiatric histories or related lived experience. Specifically, this includes the (1) BIPOC community (i.e., people who are black, indigenous, or people of color); (2) TQI+ community (i.e., people who identify as transgender, queer or questioning, intersex, or other gender identities); and (3) Spanish-speaking community.

The report also must review other states’ practices on establishing a peer-run technical assistance center that may:

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1. help peer-run respite centers hire and recruit peer support specialists and other staff;
2. promote community awareness of these respite centers;
3. evaluate and identify the need for peer respite services throughout the state;
4. evaluate the effectiveness and quality of peer respite services in the state;
5. hold peer respite services meetings throughout the state to facilitate networking, collaboration, and shared learning;
6. consult respite centers on developing peer respite services;
7. develop resources to support the supervision of peer support specialists; and
8. make recommendations on certain matters, in consultation with respite centers and stakeholders in the TQI+, BIPOC, and Spanish-speaking communities.

Specifically, this last provision includes recommendations on (1) best practices for delivering peer respite services; (2) training requirements for peer support specialists, including specialized requirements depending on the population they serve; and (3) creating a program fidelity tool to measure the extent to which the delivery of peer respite services in the state aligns with the act's requirements and best practices for these services.

§ 37 — PHYSICIAN RECRUITMENT WORKING GROUP

Extends the reporting deadline for the physician recruitment working group and adds to the group's charge the study of issues related to primary care residency and ways to keep those residents in the state

PA 22-81, § 29, required the DPH commissioner to convene a working group to advise her on ways to enhance physician recruitment in the state. This act extends by two years, from January 1, 2024, to January 1, 2026, the deadline for the group to report its findings to the commissioner and the Public Health Committee.

Existing law requires the group to examine, among other things, recruiting, retaining, and compensating primary care, psychiatric, and behavioral health care providers. The act additionally requires it to examine issues related to in-state primary care residency positions and ways to keep these physicians in Connecticut. Under the act, "primary care" is pediatrics, internal or family medicine, obstetrics and gynecology, or psychiatry.

EFFECTIVE DATE: Upon passage

§§ 38 & 39 — DISCRIMINATION AGAINST NURSING HOME APPLICANTS

Makes it a discriminatory practice under the CHRO laws for nursing homes to refuse applicants for admission solely because they received mental health services at any time

The act specifically prohibits nursing homes from refusing to admit applicants for admission solely because they received mental health services at any time. It classifies this as a discriminatory practice under the Commission on Human Rights and Opportunities (CHRO) laws. By doing so, the act allows people aggrieved by these violations, or CHRO itself, to file a complaint with CHRO alleging

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discrimination.

Under the act, “mental health services” include counseling, therapy, rehabilitation, crisis intervention, emergency services, or psychiatric medication to screen, diagnose, or treat mental illness.

The act specifies that it does not require nursing homes to admit applicants (1) who pose a direct threat to the health or safety of others, (2) who do not need a nursing home level of care according to state and federal requirements, or (3) whose admission would result in converting the nursing home into an institution for mental diseases.

Existing state regulation permits nursing homes to accept an applicant for admission with a manageable psychiatric condition if a psychiatrist, after an evaluation, determines it is medically appropriate (Conn. Agencies Regs., § 19-13-D13). In addition, federal law requires Medicaid-certified nursing homes to screen applicants for serious mental illness, intellectual disabilities, or related conditions to ensure they are not inappropriately placed in nursing homes (42 C.F.R. §§ 483.100-483.138). Other related federal laws prohibit discrimination based on various factors, including disability, in health care settings (e.g., the Americans with Disabilities Act, 42 U.S.C. §§ 12181(7)(F) & 12182).

EFFECTIVE DATE: October 1, 2024

§ 40 — PRIOR AUTHORIZATION AND PRECERTIFICATION DATA

Starting January 1, 2025, allows hospitals, outpatient surgical facilities, and physician group practices to record and keep data on employee time spent requesting prior authorizations or precertifications from health carriers; permits these entities to make the data available to the Public Health Committee, upon request

Starting January 1, 2025, the act authorizes hospitals, outpatient surgical facilities, and physician group practices (i.e., two or more physicians) to record and keep data on how much time their employees spend when requesting prior authorizations or precertifications from health carriers (e.g., insurers and HMOs) for patient admissions, services, medication, procedures, or extended stays. This includes time spent speaking directly with the health carrier, physician peer-to-peer conversations about the prior authorization or precertification, and writing appeals of a denied request.

Under the act, these entities may (1) use prior authorization and precertification codes generated by a Connecticut hospital association to uniformly record the data and (2) make the data available to the Public Health Committee, upon request of its chairpersons or ranking members.

EFFECTIVE DATE: Upon passage