General Assembly

Amendment

February Session, 2024

LCO No. **5369**

Offered by:

SEN. ANWAR, 3rd Dist.
REP. MCCARTHY VAHEY, 133rd Dist.
SEN. LOONEY, 11th Dist.
SEN. DUFF, 25th Dist.
SEN. SOMERS, 18th Dist.
SEN. MARX, 20th Dist.
SEN. COHEN, 12th Dist.
SEN. LESSER, 9th Dist.
SEN. HOCHADEL, 13th Dist.
SEN. MILLER P., 27th Dist.
SEN. MOORE, 22nd Dist.
SEN. RAHMAN, 4th Dist.
SEN. LOPES, 6th Dist.
SEN. GASTON, 23rd Dist.
SEN. MARONEY, 14th Dist.
SEN. MAHER, 26th Dist.
SEN. SLAP, 5th Dist.
SEN. CABRERA, 17th Dist.
SEN. KUSHNER, 24th Dist.
SEN. NEEDLEMAN, 33rd Dist.
SEN. WINFIELD, 10th Dist.
SEN. GORDON, 35th Dist.
SEN. MARTIN, 31st Dist.
REP. PARKER, 101st Dist.
SEN. FLEXER, 29th Dist.

To: Senate Bill No. **1** File No. 315 Cal. No. 196

(As Amended)

"AN ACT CONCERNING THE HEALTH AND SAFETY OF CONNECTICUT RESIDENTS."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. (NEW) (*Effective October 1, 2024*) (a) Each home health care agency and home health aide agency, as such terms are defined in

section 19a-490 of the general statutes, except any such agency that is licensed as a hospice organization by the Department of Public Health pursuant to section 19a-122b of the general statutes, shall, during intake of a prospective client who will be receiving services from the agency, collect and provide to any employee assigned to provide services to such client, to the extent feasible and consistent with state and federal laws, information regarding: (1) The client, including, if applicable, (A) the client's history of violence toward health care workers; (B) the client's history of substance use; (C) the client's history of domestic abuse; (D) a list of the client's diagnoses, including, but not limited to, psychiatric history; (E) whether the client's diagnoses or symptoms thereof have remained stable over time; and (F) any information concerning violent acts involving the client that is contained in judicial records or any sex offender registry information concerning the client; and (2) the location where the employee will provide services, including, if known to the agency, the (A) crime rate for the municipality in which the employee will provide services, as determined by the most recent annual report concerning crime in the state issued by the Department of Emergency Services and Public Protection pursuant to section 29-1c of the general statutes, (B) presence of any hazardous materials at the location, including, but not limited to, used syringes, (C) presence of firearms or other weapons at the location, (D) status of the location's fire alarm system, and (E) presence of any other safety hazards at the locations.

(b) To facilitate compliance with subparagraph (A) of subdivision (2) of subsection (a) of this section, each such agency shall annually review the annual report issued by the department pursuant to section 29-1c of the general statutes to collect crime-related data regarding the locations in the state where such agency's employees provide services.

(c) Notwithstanding any provision of subsection (a) or (b) of this section, no such agency shall deny the provision of services to a client solely based on (1) the inability or refusal of the client to provide the information described in subsection (a) of this section, or (2) the information collected from the client pursuant to subsection (a) of this

section.

Sec. 2. (NEW) (*Effective October 1, 2024*) (a) Each home health care agency and home health aide agency, as such terms are defined in section 19a-490 of the general statutes, except any such agency that is licensed as a hospice organization by the Department of Public Health pursuant to section 19a-122b of the general statutes, shall (1) (A) adopt and implement a health and safety training curriculum for home care workers that is consistent with the health and safety training curriculum for such workers that is endorsed by the Centers for Disease Control and Prevention's National Institute for Occupational Safety and Health and the Occupational Safety and Health Administration, including, but not limited to, training to recognize hazards commonly encountered in home care workplaces and applying practical solutions to manage risks and improve safety, and (B) provide annual staff training consistent with such health and safety curriculum; and (2) conduct monthly safety assessments with direct care staff at the agency's monthly staff meeting.

(b) The Commissioner of Social Services shall require any home health care agency and home health aide agency, except any such agency that is licensed as a hospice organization by the Department of Public Health pursuant to section 19a-122b of the general statutes, that receives reimbursement for services rendered under the Connecticut medical assistance program, as defined in section 17b-245g of the general statutes, to provide evidence of adoption and implementation of such health and safety training curriculum pursuant to subdivision (1) of subsection (a) of this section, or, at the commissioner's discretion, an alternative workplace safety training program applicable to such agency to obtain reimbursement for services provided under the medical assistance program.

(c) The commissioner may provide a rate enhancement under the Connecticut medical assistance program for any home health care agency or home health aide agency, except any such agency that is licensed as a hospice organization by the Department of Public Health pursuant to section 19a-122b of the general statutes, for timely reporting

of any workplace violence incident. For purposes of this section, "timely reporting" means reporting such incident not later than seven calendar days after its occurrence to the Department of Social Services and the Department of Public Health.

Sec. 3. (NEW) (*Effective October 1, 2024*) (a) Not later than January 1, 2025, and annually thereafter, each home health care agency and home health aide agency, as such terms are defined in section 19a-490 of the general statutes, except any such agency that is licensed as a hospice organization by the Department of Public Health pursuant to section 19a-122b of the general statutes, shall report, in a form and manner prescribed by the Commissioner of Public Health, each instance of verbal abuse that is perceived as a threat or danger by a staff member of such agency, physical abuse, sexual abuse or any other abuse by an agency client against a staff member of such agency and the actions taken by the agency to ensure the safety of the staff member.

(b) Not later than March 1, 2025, and annually thereafter, the commissioner shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding the number of reports received pursuant to subsection (a) of this section and the actions taken to ensure the safety of the staff member about whom the report was made.

Sec. 4. (*Effective from passage*) (a) Not later than January 1, 2025, the Commissioner of Social Services shall establish a home health worker safety grant program. The program shall, on or before January 1, 2027, provide incentive grants for home health care agencies and home health aide agencies, as such terms are defined in section 19a-490 of the general statutes, to provide (1) escorts for safety purposes to staff members conducting a home visit, and (2) a mechanism for staff to perform safety checks, which may include, but need not be limited to, (A) a mobile application that allows staff to access safety information relating to a client, including information collected pursuant to section 1 of this act, and a method of communicating with local police or other staff in the

event of a safety emergency, and (B) a global positioning system-enabled, wearable device that allows staff to contact local police by pressing a button or through another mechanism. The Commissioner of Social Services shall establish eligibility requirements, priority categories, funding limitations and the application process for the grant program.

(b) Not later than January 1, 2026, and annually thereafter until January 1, 2027, the commissioner shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding the number of home health care agencies and home health aide agencies that applied for and received an incentive grant from the grant program established under subsection (a) of this section, the use of incentive grant funds by such recipients and any other information deemed pertinent by the commissioner.

Sec. 5. (NEW) (*Effective October 1, 2024*) (a) Any hospital, chronic disease hospital, nursing home, behavioral health facility, multicare institution or psychiatric residential treatment facility, as such terms are defined in section 19a-490 of the general statutes, that receives reimbursement for services rendered under the Connecticut medical assistance program, as defined in section 17b-245g of the general statutes, shall adopt and implement workplace violence prevention standards that are consistent with the workplace violence prevention standards set forth by the Joint Commission or any applicable certification or accreditation agency.

(b) The Commissioner of Social Services may require any institution listed in subsection (a) of this section to provide evidence of adoption and implementation of such workplace violence prevention standards to obtain reimbursement for services provided under the medical assistance program.

Sec. 6. (*Effective from passage*) (a) The chairpersons of the joint standing committee of the General Assembly having cognizance of matters

relating to public health shall convene a working group to study staff safety issues affecting (1) home health care and home health aide agencies, as such terms are defined in section 19a-490 of the general statutes, and (2) hospice organizations licensed by the Department of Public Health pursuant to section 19a-122b of the general statutes.

(b) The working group shall include, but need not be limited to, the following members:

(1) Three employees of one or more home health care or home health aide agencies, at least one of whom shall be a direct care worker;

(2) Three employees of one or more hospice care organizations, at least one of whom shall be a direct care worker;

(3) Two representatives of a home health care or home health aide agency;

(4) One representative of a collective bargaining unit representing home health care or home health aide agency employees;

(5) One representative of a collective bargaining unit representing hospice care organizations or hospice care employees;

(6) One representative of a mobile crisis response services provider;

(7) One representative of an assertive community treatment team;

(8) One representative of a police department;

(9) One representative of an association of hospitals in the state;

(10) One representative of an association of home health care and home health aide agencies in the state;

(11) Two representatives of an association of nurses in the state;

(12) One representative of the Division of State Police within the Department of Emergency Services and Public Protection;

(13) One representative of a municipal police department in the state;

(14) One member of a labor union in the state;

(15) The Commissioner of Mental Health and Addiction Services, or the commissioner's designee;

(16) The Commissioner of Correction, or the commissioner's designee;

(17) The Commissioner of Public Health, or the commissioner's designee;

(18) The Commissioner of Social Services, or the commissioner's designee;

(19) One member or employee of the Board of Pardons and Paroles; and

(20) One member of the judiciary.

(c) The chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall schedule the first meeting of the working group, which shall be held not later than sixty days after the effective date of this section.

(d) The members of the working group shall select two cochairpersons from among the members of the working group.

(e) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall serve as administrative staff of the working group.

(f) Not later than January 1, 2025, the working group shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes. The working group shall terminate on the date that it submits such report or January 1, 2025, whichever is later.

Sec. 7. (NEW) (*Effective July 1, 2024*) (a) As used in this section:

(1) "Primary care provider" means a physician, advanced practice registered nurse or physician assistant who provides primary care services and is licensed by the Department of Public Health pursuant to title 20 of the general statutes; and

(2) "Primary care" means the medical fields of family medicine, general pediatrics, primary care, internal medicine, primary care obstetrics or primary care gynecology, without regard to board certification.

(b) On or before January 1, 2025, the Commissioner of Public Health, in consultation with the Commission on Community Gun Violence Intervention and Prevention, established pursuant to section 19a-112j of the general statutes, and the Connecticut chapters of a national professional association of physicians, a national professional association of pediatricians, a national professional association of advanced practice registered nurses and a national professional association of physician assistants, provided such chapters and associations agree to such consultation, shall develop or procure educational material concerning gun safety practices to be provided by primary care providers to patients during the patient's appointment with such patient's primary care provider. On or before February 1, 2025, the Department of Public Health shall make the educational material available to all primary care providers in the state, at no cost to the provider, and make recommendations to such primary care providers for the effective use of such educational material. Such primary care providers shall make such educational material available to each patient on an annual basis at the patient's appointment with the primary care provider, or at each appointment if the patient visits the primary care provider less frequently than annually.

Sec. 8. (*Effective from passage*) (a) The cochairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall establish a working group to

study nonalcoholic fatty liver disease, including nonalcoholic fatty liver and nonalcoholic steatohepatitis. Such study shall include, but need not be limited to, an examination of the following:

(1) The incidences of such disease in the state compared to incidences of such disease throughout the United States;

(2) The population groups most affected by and at risk of being diagnosed with such disease and the main risk factors contributing to its prevalence in such groups;

(3) Strategies for preventing such disease in high-risk populations and how such strategies can be implemented state-wide;

(4) Methods of increasing public awareness of such disease, including, but not limited to, public awareness campaigns educating the public regarding liver health;

(5) Whether implementation of a state-wide screening program for such disease in at-risk populations is recommended;

(6) Policy changes necessary to improve care and outcomes for patients with such disease;

(7) Insurance coverage and affordability issues that affect access to treatments for such disease;

(8) The creation of patient advocacy and support networks to assist persons living with such disease; and

(9) The manner in which social determinants of health influence the risk and outcomes of such disease and interventions needed to address such determinants.

(b) The working group shall include, but need not be limited to, the following members:

(1) A physician with expertise in hepatology and gastroenterology representing an institution of higher education in the state;

(2) Three persons in the state living with nonalcoholic fatty liver disease;

(3) A representative of a patient advocacy organization in the state;

(4) A social worker with experience working with communities in underserved areas in the state and addressing social determinants of health;

(5) An expert in health care policy in the state with experience in advising on regulatory frameworks, health care access and insurance issues;

(6) A nutritionist and dietician in the state with experience in providing guidance on preventative measures and dietary interventions related to nonalcoholic fatty liver disease;

(7) A community health worker who works directly with underserved communities in the state in addressing social determinants of health;

(8) A representative of a nonprofit organization in the state focused on liver health; and

(9) The Commissioner of Public Health, or the commissioner's designee.

(c) The cochairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall convene the first meeting of the working group, which shall be held not later than sixty days after the effective date of this section.

(d) The members of the working group shall select two cochairpersons from among the members of the working group.

(e) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall serve as administrative staff of the working group.

(f) Not later than January 1, 2025, the working group shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes. The working group shall terminate on the date that it submits such report or January 1, 2025, whichever is later.

Sec. 9. (*Effective from passage*) (a) The cochairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall convene a working group to study health issues experienced by nail salon workers as a result of such workers' exposure to health hazards in a nail salon. Such study shall include, but need not be limited to, (1) an identification of health hazards in a nail salon, (2) mechanisms to reduce nail salon workers' exposure to such health hazards, (3) best practices for preventing nail salon workers from acquiring health issues from exposure to health hazards in a nail salon, and (4) assessing the strengths of policies protecting nail salon workers' health that have been implemented in other states.

(b) The working group shall include, but need not be limited to, the following members:

(1) Three nail technicians, each employed by a different nail salon in the state;

(2) Three owners or managers of three different nail salons in the state;

(3) A health care professional licensed in the state with experience treating patients experiencing symptoms of an illness attributable to such patients' exposure to health hazards while working in a nail salon;

(4) A representative of a labor union in the state;

(5) An expert in occupational safety;

(6) An expert in environmental health;

(7) A director of a municipal health department in the state with more than three nail salons in the department's jurisdiction; and

(8) The Commissioner of Public Health, or the commissioner's designee.

(c) The cochairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall convene the first meeting of the working group, which shall occur not later than sixty days after the effective date of this section.

(d) The members of the working group shall select two cochairpersons from among the members of the working group.

(e) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall serve as administrative staff of the working group.

(f) Not later than January 1, 2025, the working group shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes. The working group shall terminate on the date that it submits such report or January 1, 2025, whichever is later.

Sec. 10. (*Effective from passage*) The Commissioner of Consumer Protection, in collaboration with The University of Connecticut School of Pharmacy, shall study incidences of prescription drug shortages in the state and whether the state has a role in alleviating such shortages. Not later than January 1, 2025, the commissioner shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to consumer protection and public health regarding such study and any recommendations for legislation that would help alleviate or prevent such shortages.

Sec. 11. Section 19a-490ff of the 2024 supplement to the general

statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section, (1) "board eligible" means eligible to take a qualifying examination administered by a medical specialty board after having graduated from a medical school, completed a residency program and trained under supervision in a specialty fellowship program, (2) "board certified" means having passed the qualifying examination administered by a medical specialty board to become board certified in a particular specialty, and (3) "board recertification" means recertification in a particular specialty after a predetermined time period prescribed by a medical specialty board, including, but not limited to, through participation in any required maintenance of certification program, after having passed the qualifying examination administered by the medical specialty board to become board certified in a particular specialty.

(b) No hospital, or medical review committee of a hospital, shall require, as part of its credentialing requirements (1) for a board eligible physician to acquire privileges to practice in the hospital, that the physician provide credentials of board certification in a particular specialty until five years after the date on which the physician became board eligible in such specialty, or (2) for a board certified physician to acquire or retain privileges to practice in the hospital, that the physician provide credentials of board recertification.

Sec. 12. (NEW) (*Effective January 1, 2025*) (a) For purposes of this section:

(1) "Health care provider" has the same meaning as provided in section 38a-477aa of the general statutes;

(2) "Maintenance of certification" means any process requiring periodic recertification examinations or other professional development activities to maintain specialty certification; and

(3) "Specialty certification" means any certification by a medical

board that specializes in one area of medicine and has requirements in addition to licensing requirements in this state.

(b) No insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that delivers, issues for delivery, renews, amends or continues an individual or group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes in this state on or after January 1, 2025, shall deny reimbursement to a health care provider or prevent any health care provider from participating in any provider network based solely on such health care provider's decision not to maintain a specialty certification, including, but not limited to, through participation in any maintenance of certification program, provided such health care provider does not hold such health care provider out to be a specialist under such specialty certification.

Sec. 13. (NEW) (*Effective January 1, 2025*) (a) For purposes of this section:

(1) "Health care provider" has the same meaning as provided in section 38a-477aa of the general statutes;

(2) "Maintenance of certification" means any process requiring periodic recertification examinations or other professional development activities to maintain specialty certification;

(3) "Professional liability insurance" has the same meaning as provided in section 38a-393 of the general statutes; and

(4) "Specialty certification" means any certification by a medical board that specializes in one area of medicine and has requirements in addition to licensing requirements in this state.

(b) No insurance company that delivers, issues for delivery, renews, amends or continues a professional liability insurance policy in this state on or after January 1, 2025, shall (1) deny coverage of a health care

provider based solely on such health provider's decisions not to maintain a specialty certification, including, but not limited to, through participation in a maintenance of certification program, or (2) require evidence of maintenance of such specialty certification as a prerequisite for obtaining professional liability insurance or other indemnity against liability for professional malpractice in accordance with section 20-11b of the general statutes, provided such health care provider does not hold such health care provider out to be a specialist under such specialty certification.

Sec. 14. (NEW) (*Effective October 1, 2024*) (a) As used in this section:

(1) "Dispense" has the same meaning as provided in section 21a-240 of the general statutes;

(2) "Opioid drug" has the same meaning as provided in section 20-14o of the general statutes;

(3) "Personal opioid drug deactivation and disposal system" means a product that is designed for personal use and enables a patient to permanently deactivate and destroy an opioid drug;

(4) "Pharmacist" has the same meaning as provided in section 21a-240 of the general statutes; and

(5) "Pharmacy" has the same meaning as provided in section 21a-240 of the general statutes.

(b) Each pharmacist who dispenses an opioid drug to a patient in this state may provide to such patient, at the time such pharmacist dispenses such drug to such patient, information concerning a personal opioid drug deactivation and disposal system, including, but not limited to, the Internet web site address for the Department of Mental Health and Addiction Services containing such information pursuant to section 15 of this act. Nothing in this section shall be construed to apply to a pharmacist who dispenses an opioid drug for a patient while the patient is in a facility or health care setting.

Sec. 15. (NEW) (*Effective from passage*) Not later than October 1, 2024, the Commissioner of Mental Health and Addiction Services shall post on the Department of Mental Health and Addiction Services' Internet web site information regarding personal opioid drug deactivation and disposal systems. As used in this section, "personal opioid drug deactivation and disposal system" means a product that is designed for personal use and enables a patient to permanently deactivate and destroy an opioid drug, as defined in section 20-14o of the general statutes.

Sec. 16. (*Effective from passage*) (a) As used in this section:

(1) "Opioid drug" has the same meaning as provided in section 20-14o of the general statutes; and

(2) "Personal opioid drug deactivation and disposal system" means a product that is designed for personal use and enables a patient to permanently deactivate and destroy an opioid drug.

(b) The Commissioner of Mental Health and Addiction Services, in collaboration with the Commissioners of Consumer Protection and Public Health, the Insurance Commissioner and the Governor's Prevention Partnership, shall study long-term payment options for the dispensing of personal opioid drug deactivation and disposal systems to patients in the state, including, but not limited to, at the time an opioid drug is dispensed to the patient. Not later than January 1, 2025, the Commissioner of Mental Health and Addiction Services shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and consumer protection, regarding such study.

Sec. 17. Subdivision (7) of section 31-101 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(7) "Employer" means any person acting directly or indirectly in the

interest of an employer in relation to an employee, but shall not include any person engaged in farming, or any person subject to the provisions of the National Labor Relations Act, unless the National Labor Relations Board has declined to assert jurisdiction over such person, or any person subject to the provisions of the Federal Railway Labor Act, or the state or any political or civil subdivision thereof or any religious agency or corporation, or any labor organization, except when acting as an employer, or any one acting as an officer or agent of such labor organization. An employer licensed by the Department of Public Health under section 19a-490 shall be subject to the provisions of this chapter with respect to all its employees except those licensed under **[**chapters 370 and**]** chapter 379, unless such employer is the state or any political subdivision thereof;

Sec. 18. (NEW) (*Effective January 1, 2025*) (a) As used in this section, "coronary calcium scan" means a computed tomography scan of the heart that looks for calcium deposits in the heart arteries.

(b) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes and delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2025, shall provide coverage for coronary calcium scans.

(c) The provisions of this section shall apply to a high deductible health plan, as such term is used in subsection (f) of section 38a-493 of the general statutes, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986, as amended from time to time, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account pursuant to Section 223 of said Internal Revenue Code of 1986, as amended from time to time, the provisions of this section shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223 of said Internal

Revenue Code of 1986, as applicable.

Sec. 19. (NEW) (*Effective January 1, 2025*) (a) As used in this section, "coronary calcium scan" means a computed tomography scan of the heart that looks for calcium deposits in the heart arteries.

(b) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes and delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2025, shall provide coverage for coronary calcium scans.

(c) The provisions of this section shall apply to a high deductible health plan, as such term is used in subsection (f) of section 38a-493 of the general statutes, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986, as amended from time to time, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account pursuant to Section 223 of said Internal Revenue Code of 1986, as amended from time to time, the provisions of this section shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 220 or 223 of said Internal Revenue Code, as applicable.

Sec. 20. (NEW) (*Effective from passage*) Not later than January 1, 2025, and not less than annually thereafter, each hospital licensed pursuant to chapter 368v of the general statutes, except any such hospital that is operated exclusively by the state, shall (1) submit the hospital's plans and processes to respond to a cybersecurity disruption of the hospital's operations to an audit by an independent, certified cybersecurity auditor or cybersecurity expert credentialed by the Information Systems Audit and Control Association, or similar entity that provides such credentials, to determine the adequacy of such plans and processes and identify any necessary improvements to such plans and processes, and

(2) make available for inspection on a confidential basis to the Departments of Public Health and Administrative Services and the Division of Emergency Management and Homeland Security within the Department of Emergency Services and Public Protection information regarding whether such plans and processes have been determined to be adequate pursuant to such audit and the steps the hospital is taking to implement any recommended improvements by the auditor. Any recipient of the information submitted or made available pursuant to this section shall maintain the maximum level of confidentiality allowed under law for such information and shall not disclose such information except as expressly required by law. The information submitted or made available pursuant to this section shall be exempt from disclosure under the Freedom of Information Act, as defined in section 1-200 of the general statutes.

Sec. 21. Subsection (b) of section 17b-59d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2024*):

(b) It shall be the goal of the State-wide Health Information Exchange to: (1) Allow real-time, secure access to patient health information and complete medical records across all health care provider settings; (2) provide patients with secure electronic access to their health information in accordance with 45 CFR 171; (3) allow voluntary participation by patients to access their health information at no cost; (4) support care coordination through real-time alerts and timely access to clinical information; (5) reduce costs associated with preventable readmissions, duplicative testing and medical errors; (6) promote the highest level of interoperability; (7) meet all state and federal privacy and security requirements; (8) support public health reporting, quality improvement, academic research and health care delivery and payment reform through data aggregation and analytics; (9) support population health analytics; (10) be standards-based; and (11) provide for broad local governance that (A) includes stakeholders, including, but not limited to, representatives of the Department of Social Services, hospitals, physicians, behavioral health care providers, long-term care

providers, health insurers, employers, patients and academic or medical research institutions, and (B) is committed to the successful development and implementation of the State-wide Health Information Exchange.

Sec. 22. Section 17b-59e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2024*):

(a) For purposes of this section:

(1) "Health care provider" means any individual, corporation, facility or institution licensed by the state to provide health care services; and

(2) "Electronic health record system" means a computer-based information system that is used to create, collect, store, manipulate, share, exchange or make available electronic health records for the purposes of the delivery of patient care.

(b) Not later than one year after commencement of the operation of the State-wide Health Information Exchange, each hospital licensed under chapter 368v and clinical laboratory licensed under section 19a-565 shall maintain an electronic health record system capable of connecting to and participating in the State-wide Health Information Exchange and shall apply to begin the process of connecting to, and participating in, the State-wide Health Information Exchange.

(c) Not later than two years after commencement of the operation of the State-wide Health Information Exchange, (1) each health care provider with an electronic health record system capable of connecting to, and participating in, the State-wide Health Information Exchange shall apply to begin the process of connecting to, and participating in, the State-wide Health Information Exchange, and (2) each health care provider without an electronic health record system capable of connecting to, and participating in, the State-wide Health Information Exchange shall be capable of sending and receiving secure messages that comply with the Direct Project specifications published by the federal Office of the National Coordinator for Health Information

Technology. A health care provider shall not be required to connect with the State-wide Health Information Exchange if the provider (A) possesses no patient medical records, or (B) is an individual licensed by the state that exclusively practices as an employee of a covered entity, as defined by the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, and such covered entity is legally responsible for decisions regarding the safeguarding, release or exchange of health information and medical records, in which case such covered entity is responsible for compliance with the provisions of this section.

(d) Nothing in this section shall be construed to require a health care provider to share patient information with the State-wide Health Information Exchange if (1) sharing such information is prohibited by state or federal privacy and security laws, or (2) affirmative consent from the patient is legally required and such consent has not been obtained.

(e) No health care provider shall be liable for any private or public claim related directly to a data breach, ransomware or hacking experienced by the State-wide Health Information Exchange, provided a health care provider shall be 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. Any health care provider that would violate any other law by sharing information with or connecting to the exchange shall not be required to share such information with or connect to the exchange.

[(d)**]** (f) The executive director of the Office of Health Strategy shall adopt regulations in accordance with the provisions of chapter 54 that set forth requirements necessary to implement the provisions of this section. The executive director may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided the executive director holds a public hearing at least thirty days prior to implementing such policies and procedures and publishes

notice of intention to adopt the regulations on the Office of Health Strategy's Internet web site and the eRegulations System not later than twenty days after implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are effective.

(g) Not later than eighteen months after the date of implementation of policies and procedures pursuant to subsection (f) of this section, each health care provider shall be connected to and actively participating in the State-wide Health Information Exchange. As used in this subsection, (1) "connection" includes, but is not limited to, onboarding with the exchange, and (2) "participation" means the active sharing of medical records with the exchange in accordance with applicable law including, but not limited to, the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, and 42 CFR 2.

Sec. 23. (*Effective from passage*) (a) Not later than September 1, 2025, the executive director of the Office of Health Strategy shall establish a working group to make recommendations to the office regarding the parameters of the regulations to be adopted by, and any policies and procedures to be implemented by, the office pursuant to subsection (f) of section 17b-59e of the general statutes, as amended by this act. Such recommendations shall include, but need not be limited to (1) privacy of protected health care information, (2) cybersecurity, (3) health care provider liability, (4) any contract required of health care providers to participate in the State-wide Health Information Exchange, and (5) any statutory changes that may be necessary to address any concerns raised by the working group.

(b) The working group shall consist of not more than fifteen members, including, but not limited to, (1) the executive director of the Office of Health Strategy, or the executive director's designee, who shall serve as chairperson of the working group, (2) the Health Information Technology Officer, designated pursuant to section 19a-754a of the general statutes, or the officer's designee, (3) the chairpersons and ranking members of the joint standing committee of the General

Assembly having cognizance of matters relating to public health, and (4) representatives of health care provider associations in the state, which may include associations representing hospitals, ambulatory surgical centers, physicians, women's health care providers, behavioral and mental health care providers, health care services providers for the aging, gender affirming care providers, patient advocates and health care payers.

(c) Not later than January 1, 2025, the executive director of the Office of Health Strategy shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding the recommendations of the working group.

Sec. 24. Subsection (b) of section 17b-59f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2024*):

(b) The council shall consist of the following members:

(1) One member appointed by the executive director of the Office of Health Strategy, who shall be an expert in state health care reform initiatives;

(2) The health information technology officer, designated in accordance with section 19a-754a, or the health information technology officer's designee;

(3) The Commissioners of Social Services, Mental Health and Addiction Services, Children and Families, Correction, Public Health and Developmental Services, or the commissioners' designees;

(4) The Chief Information Officer of the state, or the Chief Information Officer's designee;

(5) The chief executive officer of the Connecticut Health Insurance Exchange, or the chief executive officer's designee;

(6) The chief information officer of The University of Connecticut Health Center, or the chief information officer's designee;

(7) The Healthcare Advocate, or the Healthcare Advocate's designee;

(8) The Comptroller, or the Comptroller's designee;

(9) The Attorney General, or the Attorney General's designee;

[(9)**]** (10) Five members appointed by the Governor, one each who shall be (A) a representative of a health system that includes more than one hospital, (B) a representative of the health insurance industry, (C) an expert in health information technology, (D) a health care consumer or consumer advocate, and (E) a current or former employee or trustee of a plan established pursuant to subdivision (5) of subsection (c) of 29 USC 186;

[(10)**]** (11) Three members appointed by the president pro tempore of the Senate, one each who shall be (A) a representative of a federally qualified health center, (B) a provider of behavioral health services, and (C) a physician licensed under chapter 370;

[(11)**]** (12) Three members appointed by the speaker of the House of Representatives, one each who shall be (A) a technology expert who represents a hospital system, as defined in section 19a-486i, (B) a provider of home health care services, and (C) a health care consumer or a health care consumer advocate;

[(12)**]** (13) One member appointed by the majority leader of the Senate, who shall be a representative of an independent community hospital;

[(13)**]** (14) One member appointed by the majority leader of the House of Representatives, who shall be a physician who provides services in a multispecialty group and who is not employed by a hospital;

[(14)**]** (15) One member appointed by the minority leader of the Senate, who shall be a primary care physician who provides services in

a small independent practice;

[(15)**]** (16) One member appointed by the minority leader of the House of Representatives, who shall be an expert in health care analytics and quality analysis;

[(16)**]** (17) The president pro tempore of the Senate, or the president's designee;

[(17)**]** (18) The speaker of the House of Representatives, or the speaker's designee;

[(18)**]** (19) The minority leader of the Senate, or the minority leader's designee; and

[(19)**]** (20) The minority leader of the House of Representatives, or the minority leader's designee.

Sec. 25. (NEW) (*Effective from passage*) Not later than January 1, 2025, and annually thereafter, the Department of Public Health shall report, within available appropriations and in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding the department's work on the Healthy Brain Initiative. As used in this section, "Healthy Brain Initiative" means the National Centers for Disease Control and Prevention's collaborative approach to fully integrate cognitive health into public health practice and reduce the risk and impact of Alzheimer's disease and other dementias.

Sec. 26. (NEW) (*Effective from passage*) (a) As used in this section:

(1) "Health care provider" means any person or organization that furnishes health care services to persons with Parkinson's disease or Parkinsonism and is licensed or certified to furnish such services pursuant to chapters 370 and 378 of the general statutes; and

(2) "Hospital" has the same meaning as provided in section 19a-490 of the general statutes.

(b) Not later than April 1, 2026, the Department of Public Health, in collaboration with a public institution of higher education in the state, shall maintain and operate, within available appropriations, a state-wide registry of data on Parkinson's disease and Parkinsonism.

(c) Each hospital and each health care provider shall make available to the registry such data concerning each patient with Parkinson's disease or Parkinsonism admitted to such hospital or treated by such health care provider for such patient's Parkinson's disease or Parkinsonism as the Commissioner of Public Health shall require by regulations adopted in accordance with chapter 54 of the general statutes. Each hospital and health care provider shall provide each such patient with notice of, and the opportunity to opt out of, such disclosure.

(d) The data contained in such registry may be used by the department and authorized researchers as specified in such regulations, provided personally identifiable information in such registry concerning any such patient with Parkinson's disease or Parkinsonism shall be held confidential pursuant to section 19a-25 of the general statutes. The data contained in the registry shall not be subject to disclosure under the Freedom of Information Act, as defined in section 1-200 of the general statutes. The commissioner may enter into a contract with a nonprofit association in this state concerned with the prevention and treatment of Parkinson's disease and Parkinsonism to provide for the implementation and administration of the registry established pursuant to this section.

(e) Each hospital shall provide access to its records to the Department of Public Health, as the department deems necessary, to perform case finding or other quality improvement audits to ensure completeness of reporting and data accuracy consistent with the purposes of this section.

(f) The Department of Public Health may enter into a contract for the receipt, storage, holding or maintenance of the data or files under its control and management for the purpose of implementing the provisions of this section.

(g) The Department of Public Health may enter into reciprocal reporting agreements with the appropriate agencies of other states to exchange Parkinson's disease and Parkinsonism care data.

(h) The Department of Public Health shall establish a Parkinson's disease and Parkinsonism data oversight committee to (1) monitor the operations of the state-wide registry established pursuant to subsection (b) of this section, (2) provide advice regarding the oversight of such registry, (3) develop a plan to improve quality of Parkinson's disease and Parkinsonism care and address disparities in the provision of such care, and (4) develop short and long-term goals for improvement of such care.

(i) Said committee shall include, but need not be limited to, the following members, who shall be appointed by the Commissioner of Public Health not later than April 1, 2026: (1) A neurologist; (2) a movement disorder specialist; (3) a primary care provider; (4) a neuropsychiatrist who treats Parkinson's disease; (5) a patient living with Parkinson's disease; (6) a public health professional; (7) a population health researcher with experience in state-wide registries of health condition data; (8) a patient advocate; (9) a family caregiver of a person with Parkinson's disease; (10) a representative of a nonprofit organization related to Parkinson's disease; (11) a physical therapist with experience working with persons with Parkinson's disease; (12) an occupational therapist with experience working with persons with Parkinson's disease; (13) a speech therapist with experience working with persons with Parkinson's disease; (14) a social worker with experience providing services to persons with Parkinson's disease; (15) a geriatric specialist; and (16) a palliative care specialist. Each member shall serve a term of two years. The commissioner shall appoint, from among the members of the oversight committee, a chairperson who shall schedule the first meeting of the oversight committee on or before April 1, 2026. The Department of Public Health shall assist said committee in its work and provide any information or data that the committee deems necessary to fulfil its duties, unless the disclosure of such information or data is prohibited by state or federal law. Not later

than January 1, 2027, and annually thereafter, the chairperson of the committee shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health, regarding the work of the committee. Not later than January 1, 2027, and at least annually thereafter, such chairperson shall report to the Commissioner of Public Health regarding the work of the committee.

(j) The Commissioner of Public Health may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section. The commissioner may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulations, provided notice of intent to adopt regulations is published on the eRegulations system not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Sec. 27. (NEW) (*Effective from passage*) (a) The Commissioner of Mental Health and Addiction Services, in consultation with the Commissioner of Children and Families, shall establish, within available appropriations, a program for persons diagnosed with recent-onset schizophrenia spectrum disorder for specialized treatment early in such persons' psychosis. Such program shall serve as a hub for the state-wide dissemination of information regarding best practices for the provision of early intervention services to persons diagnosed with a recent-onset schizophrenia spectrum disorder. Such program shall address (1) the limited knowledge of (A) region-specific needs in treating such disorder, (B) the prevalence of first-episode psychosis in persons diagnosed with such disorder, and (C) disparities across different regions in treating such disorder, (2) uncertainty regarding the availability and readiness of clinicians to implement early intervention services for persons diagnosed with such disorder and such persons' families, and (3) funding of and reimbursement for early intervention services available to persons diagnosed with such disorder.

(b) The program established pursuant to subsection (a) of this section shall perform the following functions:

(1) Develop structured curricula, online resources and videoconferencing-based case conferences to disseminate information for the development of knowledge and skills relevant to patients with first-episode psychosis and such patients' families;

(2) Assess and improve the quality of early intervention services available to persons diagnosed with a recent-onset schizophrenic spectrum disorder across the state;

(3) Provide expert input on complex cases of a recent-onset schizophrenic spectrum disorder and launch a referral system for consultation with persons having expertise in treating such disorders;

(4) Share lessons and resources from any campaigns aimed at reducing the duration of untreated psychosis to improve local pathways to care for persons with such disorders;

(5) Serve as an incubator for new evidence-based treatment approaches and pilot such approaches for deployment across the state;

(6) Advocate for policies addressing the financing, regulation and provision of services for persons with such disorders; and

(7) Collaborate with state agencies to improve outcomes for persons diagnosed with first-episode psychosis in areas including, but not limited to, crisis services and employment services.

(c) Not later than January 1, 2025, and annually thereafter, the Commissioner of Mental Health and Addiction Services shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health, regarding the functions and outcomes of the program for specialized treatment early in psychosis and any recommendations for legislation to address the needs of persons diagnosed with recent-onset schizophrenic spectrum

disorders.

Sec. 28. (*Effective from passage*) (a) The cochairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall establish a working group to study and make recommendations concerning methods of addressing loneliness and isolation experienced by persons in the state and to improve social connection among such persons, including, but not limited to, through the establishment of a pilot program that utilizes technology to combat loneliness and foster social engagement. The working group shall perform the following functions:

(1) Evaluate the causes of and other factors contributing to the sense of isolation and loneliness experienced by persons in the state;

(2) Evaluate methods of preventing and eliminating the sense of isolation and loneliness experienced by persons in the state;

(3) Recommend local activities, systems and structures to combat isolation and loneliness in the state, including, but not limited to, opportunities for organizing or enhancing in-person gatherings within communities, especially for persons who have been living in isolation for extended periods of time; and

(4) Explore the possibility of creating municipal-based social connection committees to address the challenges of and potential solutions for combatting isolation and loneliness experienced by persons in the state.

(b) The working group shall include, but need not be limited to, the following members:

(1) A high school teacher in the state;

(2) Two representatives of an alliance of private and public entities in the state that recognize the importance of, and need for, addressing loneliness and social disconnectedness among residents of all ages across the state;

(3) A dining hall manager of a soup kitchen in a suburban area of the state;

(4) Three high school students of a high school in the state, including one student who identifies as a member of the LGBTQ+ community, one student who identifies as female and one student who identifies as male;

(5) A student of a school of public health at an institution of higher education in the state;

(6) A student of a school of social work at an institution of higher education in the state;

(7) A resident of an assisted living facility for veterans in the state;

(8) A resident of an assisted living facility in a suburban town of the state;

(9) A member of the administration of a senior center in the state;

(10) A librarian from a library in an urban area of the state;

(11) A representative of an organization serving children in an urban area of the state;

(12) A representative of an organization that represents municipalities in the state;

(13) A representative of an organization that represents small towns in the state;

(14) A representative of an organization in the state that is working on policies to improve planning and zoning laws to create an inclusive society and improve access to transit-oriented development in the state;

(15) A representative of an organization in the state that is working to improve and create more walkable and accessible main streets in towns and municipalities in the state;

(16) A representative of an organization in the state that advocates for persons with a physical disability;

(17) An expert in digital health and identifying safe digital education;

(18) A representative of an organization in the state that develops mobile applications that are intended to address loneliness and isolation;

(19) A representative of an organization that is exploring the use of technology to address loneliness and isolation;

(20) A psychiatrist who treats adolescents in the state;

(21) A psychiatrist who treats adults in the state;

(22) A librarian from a library in a rural area of the state;

(23) A social worker who practices in an urban area of the state;

(24) The Commissioner of Mental Health and Addiction Services, or the commissioner's designee; and

(25) The Commissioner of Children and Families, or the commissioner's designee.

(c) The cochairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall schedule the first meeting of the working group, which shall be held not later than sixty days after the effective date of this section.

(d) The members of the working group shall elect two chairpersons from among the members of the working group.

(e) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall serve as administrative staff of the working group.

(f) Not later than January 1, 2025, the working group shall submit a

report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes. The working group shall terminate on the date that it submits such report or January 1, 2025, whichever is later.

Sec. 29. (*Effective from passage*) (a) The chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall establish a working group to examine hospice services for pediatric patients across the state. The working group shall include, but need not be limited to, the following members:

(1) At least one representative of each pediatric hospice association in the state;

(2) One representative of each organization licensed as a hospice by the Department of Public Health pursuant to section 19a-122b of the general statutes;

(3) At least one representative of an association of hospitals in the state;

(4) One representative each of two children's hospitals in the state;

(5) One pediatric oncologist;

(6) One pediatric intensivist;

(7) The chairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to public health;

(8) The Commissioner of Public Health, or the commissioner's designee; and

(9) The Commissioner of Social Services, or the commissioner's designee.

(b) The working group shall be responsible for the following:

(1) Reviewing existing hospice services for pediatric patients across the state;

(2) Making recommendations for appropriate levels of hospice services for pediatric patients across the state; and

(3) Evaluating payment and funding options for pediatric hospice care.

(c) The cochairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall schedule the first meeting of the working group, which shall be held not later than sixty days after the effective date of this section.

(d) The members of the working group shall elect two chairpersons from among the members of the working group.

(e) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall serve as administrative staff of the working group.

(f) Not later than March 1, 2025, the chairpersons of the working group shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health concerning the findings of the working group.

Sec. 30. (NEW) (*Effective from passage*) Not later than July 1, 2025, and at the time of hiring of each new member of its nursing staff, each organization licensed as a hospice by the Department of Public Health pursuant to section 19a-122b of the general statutes shall encourage its nursing staff to spend three weeks each in a pediatric intensive care unit, pediatric oncology unit and pediatric hospice facility to (1) enhance the skills and expertise of hospice nurses in pediatric care; and (2) prepare hospice nurses for future roles in pediatric hospice care.

Sec. 31. Section 19a-563h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section, "direct care" means hands-on care provided by a registered nurse, licensed pursuant to chapter 378, licensed practical nurse, licensed pursuant to chapter 378, or a nurse's aide, registered pursuant to chapter 378a, to residents of nursing homes, as defined in section 19a-563, including, but not limited to, assistance with feeding, bathing, toileting, dressing, lifting and moving, administering medication, promoting socialization and personal care services, but does not include food preparation, housekeeping, laundry services, maintenance of the physical environment of the nursing home or performance of administrative tasks.

[(a)**]** (b) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of three hours of direct care per resident per day, and (2) modify staffing level requirements for social work and recreational staff of nursing homes such that the requirements (A) for social work, a number of hours that is based on one full-time social worker per sixty residents and that shall vary proportionally based on the number of residents in the nursing home, and (B) for recreational staff are lower than the current requirements, as deemed appropriate by the Commissioner of Public Health.

[(b)**]** (c) The commissioner shall adopt regulations in accordance with the provisions of chapter 54 that set forth nursing home staffing level requirements to implement the provisions of this section. The Commissioner of Public Health may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulations, provided notice of intent to adopt regulations is published on the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Sec. 32. Subdivision (7) of section 38a-591a of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(7) "Clinical peer" means a physician or other health care professional who:

(A) **[**holds**]** For a review other than one specified under subparagraph (B) or (C) of subdivision (38) of this section, holds a nonrestricted license in a state of the United States **[**and**]** in the same **[**or similar**]** specialty as **[**typically manages**]** the treating physician or other health care professional who is managing the medical condition, procedure or treatment under review; **[**, and**]** or

(B) **[**for**]** For a review specified under subparagraph (B) or (C) of subdivision (38) of this section concerning:

(i) **[**a**]** A child or adolescent substance use disorder or a child or adolescent mental disorder, holds (I) a national board certification in child and adolescent psychiatry, or (II) a doctoral level psychology degree with training and clinical experience in the treatment of child and adolescent substance use disorder or child and adolescent mental disorder, as applicable; **[**,**]** or

(ii) **[**an**]** An adult substance use disorder or an adult mental disorder, holds (I) a national board certification in psychiatry, or (II) a doctoral level psychology degree with training and clinical experience in the treatment of adult substance use disorders or adult mental disorders, as applicable.

Sec. 33. Subsection (a) of section 38a-591d of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2025*):

(a) (1) Each health carrier shall maintain written procedures for (A) utilization review and benefit determinations, (B) expedited utilization review and benefit determinations with respect to prospective urgent

care requests and concurrent review urgent care requests, and (C) notifying covered persons or covered persons' authorized representatives of such review and benefit determinations. Each health carrier shall make such review and benefit determinations within the specified time periods under this section.

(2) In determining whether a benefit request shall be considered an urgent care request, an individual acting on behalf of a health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that any benefit request (A) determined to be an urgent care request by a health care professional with knowledge of the covered person's medical condition, or (B) specified under subparagraph (B) or (C) of subdivision (38) of section 38a-591a shall be deemed an urgent care request.

(3) (A) At the time a health carrier notifies a covered person, a covered person's authorized representative or a covered person's health care professional of an initial adverse determination that was based, in whole or in part, on medical necessity, of a concurrent or prospective utilization review or of a benefit request, the health carrier shall notify the covered person's health care professional (i) of the opportunity for a conference as provided in subparagraph (B) of this subdivision, and (ii) that such conference shall not be considered a grievance of such initial adverse determination as long as a grievance has not been filed as set forth in subparagraph (B) of this subdivision.

(B) After a health carrier notifies a covered person, a covered person's authorized representative or a covered person's health care professional of an initial adverse determination that was based, in whole or in part, on medical necessity, of a concurrent or prospective utilization review or of a benefit request, the health carrier shall offer a covered person's health care professional the opportunity to confer, at the request of the covered person's health care professional, with a clinical peer of such health carrier, provided such covered person, covered person's authorized representative or covered person's health care professional has not filed a grievance of such initial adverse determination prior to

such conference. Such conference shall not be considered a grievance of such initial adverse determination. Such health carrier shall grant such clinical peer the authority to reverse such initial adverse determination.

Sec. 34. Section 38a-498a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2025*):

(a) No individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469, delivered, issued for delivery or renewed in this state, on or after **[**October 1, 1996**]** January 1, 2025, shall direct or require an enrollee to obtain approval from the insurer or health care center prior to (1) calling a 9-1-1 local prehospital emergency medical service system whenever such enrollee is confronted with a life or limb threatening emergency, or (2) transporting such enrollee when medically necessary by ambulance to a hospital. For purposes of this section, a "life or limb threatening emergency" means any event which the enrollee believes threatens **[**his**]** such enrollee's life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

(b) No insurer or health care center subject to the provisions of subsection (a) of this section shall deny payment to any ambulance provider responding to a 9-1-1 local prehospital emergency medical service system call on the basis that the enrollee did not obtain approval from such insurer or health care center prior to calling such emergency medical service system or prior to transporting such enrollee when medically necessary by ambulance to a hospital.

Sec. 35. Section 38a-525a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2025*):

(a) No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469, delivered, issued for delivery or renewed in this state, on or after **[**October 1, 1996**]** January 1, 2025, shall direct or require an enrollee to obtain approval from the insurer or health care center prior to (1) calling

a 9-1-1 local prehospital emergency medical service system whenever such enrollee is confronted with a life or limb threatening emergency, or (2) transporting such enrollee when medically necessary by ambulance to a hospital. For purposes of this section, a "life or limb threatening emergency" means any event which the enrollee believes threatens **[**his**]** such enrollee's life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

(b) No insurer or health care center subject to the provisions of subsection (a) of this section shall deny payment to any ambulance provider responding to a 9-1-1 local prehospital emergency medical service system call on the basis that the enrollee did not obtain approval from such insurer or health care center prior to calling such emergency medical service system or prior to transporting such enrollee when medically necessary by ambulance to a hospital.

Sec. 36. (NEW) (*Effective October 1, 2024*) (a) As used in this section:

(1) "BIPOC" means a person who is black, indigenous or a person of color;

(2) "Peer-run organization" means a nonprofit organization that (A) is controlled and operated by persons who have psychiatric histories or have experienced other life-interrupting challenges, and (B) provides a place for support and advocacy for persons who experience similar challenges, including, but not limited to, peer respite services and peer support services;

(3) "Peer-run respite center" means a facility that is operated by a peer-run organization in a safe, physical space that employs peer support specialists to provide peer respite services and peer support services for persons age eighteen and older who are experiencing emotional or mental distress, either as an immediate precursor to or as part of a mental health crisis;

(4) "Peer respite services" means voluntary, trauma-informed, short-

term services provided to adults in a home-like environment that are the least restrictive of individual freedom, culturally competent and focus on recovery, resiliency and wellness;

(5) "Peer support services" means assistance that promotes engagement, socialization, recovery, self-sufficiency, self-advocacy, development of natural supports and identification of personal strengths;

(6) "Peer support specialist" means a person who has a psychiatric history or has experienced similarly life-interrupting challenges, who has experience in the provision of peer respite services and peer support services and has completed training specified by the Commissioner of Mental Health and Addiction Services; and

(7) "TQI+" means persons who identify as transgender, queer or questioning, intersex or other gender identities.

(b) The Commissioner of Mental Health and Addiction Services shall establish, within available appropriations, a peer-run respite center. The commissioner shall contract with a peer-run organization to operate such peer-run respite center.

(c) Not later than October 1, 2025, the commissioner shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding the peer-run respite center and post such report on the Department of Mental Health and Addiction Services' Internet web site. Such report shall (1) identify any barriers to implementing the peer-run respite center established pursuant to this section and include recommendations for addressing such barriers; (2) share data regarding the outcomes and effectiveness of the peer-run respite center and, based on such data, make recommendations regarding the establishment of additional peer-run respite centers in the state, including, but not limited to, the establishment of peer-run respite centers managed, operated and controlled by members of the BIPOC, TQI+ and Spanish-speaking

communities who have psychiatric histories or related lived experience; and (3) review other states' practices regarding the establishment of a peer-run technical assistance center that may (A) assist peer-run respite centers in hiring and recruiting peer support specialists and other staff, (B) promote community awareness of peer-run respite centers, (C) evaluate and identify the need for peer respite services in communities throughout the state, (D) evaluate the effectiveness and quality of peer respite services in the state, (E) convene peer respite services meetings throughout the state to facilitate networking, collaboration and shared learning, (F) consult peer-run respite centers regarding development of peer respite services, (G) develop resources to support the supervision of peer support specialists, and (H) in consultation with peer-run respite centers and stakeholders in the TQI+, BIPOC and Spanish-speaking communities, develop recommendations regarding (i) best practices for delivering peer respite services, (ii) training requirements for peer support specialists, including specialized training requirements depending on the population that such specialists serve, and (iii) the establishment of a program fidelity tool to measure the extent to which the delivery of peer respite services in the state adheres to the provisions of this section and best practices for the delivery of peer respite services.

Sec. 37. Section 29 of public act 22-81 is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) **[**On or before January 1, 2023, the**]** The Commissioner of Public Health shall convene a working group to advise the commissioner regarding methods to enhance physician recruitment in the state. The working group shall examine issues that include, but need not be limited to, (1) recruiting, retaining and compensating primary care, psychiatric and behavioral health care providers; (2) the potential effectiveness of student loan forgiveness; (3) barriers to recruiting and retaining physicians as a result of covenants not to compete, as defined in section 20-14p of the general statutes; (4) access to health care providers; (5) the effect, if any, of the health insurance landscape on limiting health care access; (6) barriers to physician participation in health care networks; **[**and**]** (7) assistance for graduate medical

education training; and (8) issues related to primary care residency positions in the state and methods to retain physicians who perform their primary care residency in the state. As used in this subsection, "primary care" means pediatrics, internal medicine, family medicine, obstetrics and gynecology or psychiatry.

(b) The working group convened pursuant to subsection (a) of this section shall include, but need not be limited to, the following members:

(1) A representative of a hospital association in the state; (2) a representative of a medical society in the state; (3) a physician licensed under chapter 370 of the general statutes with a small group practice; (4) a physician licensed under chapter 370 of the general statutes with a multisite group practice; (5) one representative each of at least three different schools of medicine; (6) a representative of a regional physician recruiter association; (7) the human resources director of at least one hospital in the state; (8) a member of a patient advocacy group; and (9) four members of the general public. The working group shall elect chairpersons from among its members. As used in this subsection, "small group practice" means a group practice comprised of less than eight full-time equivalent physicians and "multisite group practice" means a group practice comprised of over one hundred full-time equivalent physicians practicing throughout the state.

(c) On or before January 1, **[**2024**]** 2026, the working group shall report, in accordance with the provisions of section 11-4a of the general statutes, its findings to the commissioner and to the joint standing committee of the General Assembly having cognizance of matters relating to public health.

Sec. 38. (NEW) (*Effective October 1, 2024*) (a) As used in this section, (1) "direct threat" has the same meaning as provided in 28 CFR 35.104, as amended from time to time, (2) "institution for mental diseases" has the same meaning as provided in 42 CFR 435.1010, as amended from time to time, (3) "nursing home" has the same meaning as provided in section 19a-490 of the general statutes, and (4) "mental health services"

means counseling, therapy, rehabilitation, crisis intervention, emergency services or psychiatric medication for the screening, diagnosis or treatment of mental illness.

(b) It shall be a discriminatory practice in violation of this section for any nursing home to reject an applicant for admission to such nursing home solely on the basis that such person has, at any time, received mental health services. Nothing in this subsection shall be construed to require a nursing home to admit a person as a resident if (1) such person poses a direct threat to the health or safety of others, (2) such person does not require the level of care provided in a nursing home as determined in accordance with applicable state and federal requirements, or (3) admitting such person as a resident would result in converting the nursing home into an institution for mental diseases.

Sec. 39. Subdivision (8) of section 46a-51 of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(8) "Discriminatory practice" means a violation of section 4a-60, 4a-60a, 4a-60g, 31-40y, subsection (b), (d), (e) or (f) of section 31-51i, subparagraph (C) of subdivision (15) of section 46a-54, subdivisions (16) and (17) of section 46a-54, section 46a-58, 46a-59, 46a-60, 46a-64, 46a-64c, 46a-66 **[**,**]** or 46a-68, sections 46a-68c to 46a-68f, inclusive, **[**or**]** sections 46a-70 to 46a-78, inclusive, subsection (a) of section 46a-80, **[**or**]** sections 46a-81b to 46a-81o, inclusive, **[**and**]** sections 46a-80b to 46a-80e, inclusive, **[**and**]** sections 46a-80k to 46a-80m, inclusive, or section 38 of this act;

Sec. 40. (NEW) (*Effective from passage*) On and after January 1, 2025, each hospital and outpatient surgical facility, as such terms are defined in section 19a-490bb of the general statutes, and each group practice, as defined in section 19a-486i of the general statutes, may record and maintain data regarding the amount of time spent when an employee of the hospital, outpatient surgical facility or group practice requests prior authorization for or precertification of an admission, service,

medication, procedure or extension of stay from a health carrier for a patient of the hospital, outpatient surgical facility or group practice, including, but not limited to, speaking directly with the health carrier, physician peer-to-peer conversations regarding the prior authorization or precertification and writing appeals of a denial of any request for a prior authorization or precertification. Each hospital, outpatient surgical facility and group practice may (1) use preauthorization and precertification codes generated by a hospital association in the state to uniformly record such data, and (2) make such data available to the joint standing committee of the General Assembly having cognizance of matters relating to public health upon the request of the chairpersons and ranking members of such committee."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2024*	New section
Sec. 2	*October 1, 2024*	New section
Sec. 3	*October 1, 2024*	New section
Sec. 4	*from passage*	New section
Sec. 5	*October 1, 2024*	New section
Sec. 6	*from passage*	New section
Sec. 7	*July 1, 2024*	New section
Sec. 8	*from passage*	New section
Sec. 9	*from passage*	New section
Sec. 10	*from passage*	New section
Sec. 11	*from passage*	19a-490ff
Sec. 12	*January 1, 2025*	New section
Sec. 13	*January 1, 2025*	New section
Sec. 14	*October 1, 2024*	New section
Sec. 15	*from passage*	New section
Sec. 16	*from passage*	New section
Sec. 17	*October 1, 2024*	31-101(7)
Sec. 18	*January 1, 2025*	New section
Sec. 19	*January 1, 2025*	New section
Sec. 20	*from passage*	New section
Sec. 21	*July 1, 2024*	17b-59d(b)
Sec. 22	*July 1, 2024*	17b-59e
Sec. 23	*from passage*	New section

Sec. 24	*July 1, 2024*	17b-59f(b)
Sec. 25	*from passage*	New section
Sec. 26	*from passage*	New section
Sec. 27	*from passage*	New section
Sec. 28	*from passage*	New section
Sec. 29	*from passage*	New section
Sec. 30	*from passage*	New section
Sec. 31	*from passage*	19a-563h
Sec. 32	*January 1, 2026*	38a-591a(7)
Sec. 33	*January 1, 2025*	38a-591d(a)
Sec. 34	*January 1, 2025*	38a-498a
Sec. 35	*January 1, 2025*	38a-525a
Sec. 36	*October 1, 2024*	New section
Sec. 37	*from passage*	PA 22-81, Sec. 29
Sec. 38	*October 1, 2024*	New section
Sec. 39	*October 1, 2024*	46a-51(8)
Sec. 40	*from passage*	New section