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

2021 REGULAR AND SPECIAL SESSIONS OF THE CONNECTICUT GENERAL ASSEMBLY

PREPARED BY:

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TABLE OF ACRONYMS

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

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I. BUDGET IMPLEMENTER ACT

1. PUBLIC ACT 21-2. AN ACT CONCERNING PROVISIONS RELATED TO REVENUE AND OTHER ITEMS TO IMPLEMENT THE STATE BUDGET FOR THE BIENNIUM ENDING JUNE 30, 2023.
   Effective as noted

   § 83 – Managed Care Contracts
   Effective October 1, 2021

   This Section applies to "managed care contracts," which are contracts between health carriers and providers. The Section is aimed at improving transparency regarding a health carrier's use of provider manuals, policies and other documents incorporated by reference into managed care contracts with provisions requiring prior notice and an appeal process for any material changes to these documents.

   If a contract is entered into, renewed or amended *before* July 1, 2022, this Section requires that the health carrier timely notify any participating provider of any change to the provisions of the contract, including documents incorporated by reference into the contract, that will result in a material change to the contract. The contract must contain definitions of "timely notify" and "material change" under this new notice requirement.

   Moreover, if the contract is entered into, renewed or amended *after* July 1, 2022, this Section requires that the contract contain a provision requiring that the health carrier provide ninety (90) days advance written notice before putting into effect any changes to the contract and any changes to provider manuals and policies or other documents incorporated by reference into the contract if those changes would cause a material change to the contract or the procedures that a participating provider must follow under the contract. The contract must also include provisions disclosing the 90-day advance notice requirement and what is considered a "material change" as well as provisions giving the provider a right to appeal any proposed changes to the provisions of the contract, other documents, provider manuals or policies that would cause such material change to the contract.

   § 145 – COVID-19 Vaccination Information
   Effective June 23, 2021

   This Section requires DPH to, upon request, provide to any person vaccinated for COVID-19 with the information provided to DPH by a COVID-19 vaccination provider regarding the individual's vaccination status. If the individual is a minor, the information must be provided to the minor's parents or guardian. DPH is prohibited from disclosing this information to any other person or entity unless authorized by the individual or the minor's parent or guardian.

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§§ 147-153 – Use of Electronic Communications for State Proceedings
Section 147 is effective June 23, 2021; sections 148-153 are effective July 1, 2021.

These sections address use of electronic communications for state proceedings. Section 147 provides for definitions of certain terms involving electronic communications that were used during the COVID-19 pandemic and will have continuing use in the future. "Electronic equipment" is defined as any technology that facilitates real-time public access to meetings, including but not limited to, telephonic, video or other conferencing platforms. "Electronic transmission" is defined as any form or process of communication not directly involving the physical transfer of paper or another tangible medium, which is capable of being retained, retrieved and reproduced by the recipient and is retrievable in paper form by the recipient.

Section 148 expands the ability of the Freedom of Information Commission to use electronic transmissions as a form of notice in proceedings involving the Freedom of Information Act. Electronic transmissions may be used in instances like the denial of the right to inspect or copy certain records, the right to attend public agency meetings, notification of penalties, hearings or other rights under the Freedom of Information Act. Use of electronic transmissions will be presumed as timely and proper notice in such instances.

Section 149 extends the ability of public agencies to hold a public meeting that is accessible by means of electronic equipment or by the combination of electronic equipment and in-person attendance to April 30, 2022. Notice of such meetings must be posted at the agency's office and online at least forty-eight (48) hours in advance. The agenda must be posted at least twenty-four (24) hours in advance of the meeting and must be made available in the following locations: (1) in the agency's regular office or place of business; (2) in the office and on the Secretary of the State's website for any such public agency of the State or quasi-public agency, in the office of the clerk of such subdivision for any public agency of a political subdivision of the State that is not a quasi-public agency, or in the office of the clerk of each municipal member of any multitown district or agency; and (3) if the agency has a website, then on such website. Such notice and agenda must include instructions for the public, to attend and provide comment or otherwise participate in the meeting, by means of electronic equipment or in person.

For meetings held using only electronic equipment, the agency must provide, upon written request, any member of the public with a physical location and any equipment needed to attend the meeting in real-time and the ability to participate as if the person attended in-person. The agency must ensure the meeting is recorded or transcribed and posted on the agency's website within seven (7) days following the meeting and host it for at least forty-five (45) days following the meeting. If a quorum of the agency's members attends the meeting from the same physical location, then members of the public must also be allowed to attend in-person. If an interruption of the electronic equipment occurs, the meeting must resume either in-person or when a quorum is reached either in-person, virtually or in combination.

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The remaining sections address electronic notice of public meetings, posting of public meeting adjournments on the agency website and termination of electronic access for disorderly participants in public meetings held electronically.

§ 289 – Establishment of COVID-19 Assistance for Essential Workers
Effective October 1, 2021

This Section establishes the Connecticut Essential Workers COVID-19 Assistance Program and the "Connecticut Essential Workers COVID-19 Assistance Fund." This program will offer assistance from the Fund to "affected persons" on a first-come, first-served basis until June 30, 2024. Applications may be submitted starting October 1, 2021.

An "affected person" means an "essential employee" who died or was unable to work due to a laboratory confirmed case or an officially diagnosed case of COVID-19 between March 10, 2020 and July 20, 2021. Employees who contracted the virus despite having the capacity to work solely from home or who contracted the virus at work despite the option to work at home are not eligible.

"Essential employee" means any person employed in a category recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices as of February 20, 2021, to receive a COVID-19 vaccination in phase 1a or 1b of the COVID-19 vaccination program.

To apply for assistance, an affected person with a pending COVID-19 related workers' compensation claim must submit a claim by no later than July 20, 2022. Affected persons without pending COVID-19 related workers' compensation claims must submit a claim no later than one (1) year after the date they were initially unable to work due to COVID-19 or by July 20, 2022, whichever is later.

Funds will be payable retroactively from the date such person was initially unable to work due to COVID-19, but not earlier than March 10, 2020 and not later than July 20, 2021.

A claim must include a certificate from a medical professional showing a laboratory test or diagnosis of COVID-19 and that the person was required to quarantine, preventing such person from performing employment duties or requiring medical treatment.

For claims of "uncompensated leave," the claimant must show weekly earnings in the eight (8) weeks before the diagnosis, unless they were not employed by their employer at the time along with proof of uncompensated leave due to COVID-19.

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"Uncompensated leave" means the wages or salary lost by an affected person unable to work due to contracting COVID-19 or symptoms later confirmed to be COVID-19, at any time during the public health emergencies declared on March 10, 2020 or its extensions. Uncompensated leave does not include any leave from employment for which the affected person received paid leave through a plan provided by the employer or pursuant to other state or federal law.

Aid will be calculated at 75% of the affected person's average weekly earnings, minus deductions, during the eight (8) weeks prior to becoming unable to work due to COVID-19. Deductions to the average weekly earnings will be made for federal and state taxes, the federal Insurance Contributions Act and any state unemployment and disability benefits. Aid will also include all documented out-of-pocket medical costs related to COVID-19, including but not limited to, mental health services and certain burial expenses.

This Section addresses the required timing for responses to claims as well as the reconsideration and appeal process. Separate pending workers' compensation claims related to COVID-19 will not bar recovery through this program but will be offset by the amount a person receives for uncompensated leave under this Section. Any aid received through this program will be offset by any workers' compensation benefits already paid for uncompensated leave or out-of-pocket medical costs.

Any assistance provided and received under this program will not be considered income for the purposes of the State's personal income tax law or other state tax laws.

§ 290 – Protection from Discrimination for Filing Claims
Effective June 23, 2021

This Section protects employees from discrimination or discharge due to filing workers' compensation claims and claims under the Connecticut Essential Workers COVID-19 Assistance Fund. Employers may not deliberately misinform or dissuade employees from filing a claim under the Connecticut Essential Workers COVID-19 Assistance Fund. Any employee who is discharged, disciplined or deliberately misinformed or dissuaded from filing a workers' compensation claim or from making a claim under the Connecticut Essential Workers COVID-19 Assistance Fund may bring a civil cause of action against the employer or file a complaint with the Chairman of the Workers' Compensation Commission.

§ 291 – Amounts Recoverable for Burial Expenses
Effective June 23, 2021

This Section amends the amounts recoverable for burial expenses under the Workers' Compensation Act. For employees who died before June 23, 2021, $4,000 may be paid for burial

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expenses. For employees who died on or after June 23, 2021, $12,000 may be paid. These amounts will be adjusted annually, every January, beginning January 1, 2022.

§§ 306; 308 – Allocation of Certain Funds to DSS
Effective June 23, 2021

Section 306 sets forth the allocation of federal funds designated for the State pursuant to the American Rescue Plan Act of 2021. Included in the nearly $600 million allocation for FY 2022 is $10 million to DSS for "Nursing Home Facility Support." Section 308 requires that unexpended balances of certain funds appropriated in 2019 not lapse and be transferred and made available to various agencies, including the DSS for Medicaid. Specific allocations to DSS include: (1) up to $1.5 million to fund the State's share of an increase in the personal needs allowance to $75 for FY 2022 and FY 2023; (2) up to $40 million for FY 2022 "for nursing home settlement (temporary rate increases);" and (3) up to $2.5 million for FY 2022 and FY 2023 "for social worker staffing at nursing homes."

§ 317 – Increase to Personal Needs Allowance
Effective July 1, 2021

This Section increases the personal needs allowance for residents of long-term care facilities from $60 to $75 per month.

§ 318 – Increase to Monthly Personal Fund Allowance
Effective July 1, 2021

This Section increases the permissible monthly personal fund allowance for residents of nursing homes, chronic disease hospitals and state humane institutions who are medical assistance recipients from $60 to $75 per month.

§ 319 – Medicaid Reimbursement Methodology for Nursing Home Services
Effective June 23, 2021

This Section amends the statute addressing implementation of an acuity-based rate methodology for Medicaid reimbursement of nursing home services. The Section requires that DSS implement the new methodology effective July 1, 2022 and outlines the components of the new system for setting nursing home Medicaid rates each year after that date based on cost years ending on September 30th:

(1) The methodology effective July 1, 2022 will include case-mix adjustments to the direct care component based on Minimum Data Set data and cost data reported for the year ending September 30, 2019, and these adjustments will be updated quarterly. After DSS models the case-mix

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adjustments, it must evaluate the impact on a facility by facility basis and, not later than, October 1, 2021, make recommendations to OPM and submit a report on the recommendations to the General Assembly's Appropriations and Human Services Committees on any adjustments needed to transition to the new methodology by July 1, 2022. The evaluation may include a review of inflationary allowances, case mix and budget adjustment factors as well as stop loss and stop gain corridors along with the ability to make adjustments within available appropriations.

(2) Nursing homes must start complying with collection and reporting of quality metrics specified by DSS beginning July 1, 2022. DSS must consult with the nursing home industry, consumers, employees and DPH in developing these quality metrics. Beginning July 1, 2022, rate adjustments based on quality metrics will be phased in, starting with a period of reporting only.

(3) DSS must establish geographic peer groupings of facilities pursuant to regulations.

(4) Allowable costs are divided into five components: (i) direct costs (capped at 135% of the median allowable cost of the peer grouping); (ii) indirect costs (capped at 115% of the state-wide median allowable cost); (iii) fair rent based on the applicable CON approval; (iv) capital-related costs (no cap) and (v) administrative and general costs (capped at state-wide median allowable cost).

(5) In the DSS Commissioner's discretion and within available appropriations, DSS may provide a pro rata fair rent increase to facilities with documented fair rent additions placed in service in the cost year ending September 30, 2020 (and not otherwise included in issued rates).

(6) There will be no rate increases based on inflation or any other inflationary factor for FY 2022 and FY 2023 (however, this provision states "unless otherwise authorized under (1) above," presumably after the evaluation and reports that must be made under that requirement).

(7) Minimum allowable patient days is set at 90% of capacity, but if a facility has undergone a change in ownership, is a new facility or facility certified for additional beds, a lower occupancy rate is permitted for the first three (3) months of operation after initial licensure.

§ 320 – Rates of Payment for Nursing Homes and RCHs
Effective July 1, 2021

This Section amends Section 17b-340, which contains extensive provisions governing rate-setting for nursing homes as well as RCHs. The Section clarifies that nursing home rates will be set in accordance with its provisions prior to July 1, 2022 when the new acuity-based rate system takes effect. Accordingly, this Section amends the statute to require that the DSS Commissioner, within available appropriations, increase nursing home rates for the purpose of wage and benefit enhancements for facility employees effective July 1, 2021 and July 1, 2022. Under this Section,

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if a facility that receives such a rate adjustment does not provide increases in employee salaries before July 31, 2021 (for the July 1, 2021 rate increase) or before July 31, 2022 (for the July 1, 2022 rate increase), respectively, such facility may be subject to a rate decrease in the same amount as the rate adjustment.

This Section also revises provisions governing RCH rates. For FY 2022 and FY 2023, an RCH may receive a rate increase for a capital improvement approved by DSS for the health and safety of the resident during the FY, but only to the extent rate increases are within available appropriations. In addition, for FY 2022 and FY 2023, RCH rates will be based on rates in effect for FY 2021 inflated by the gross domestic product deflator applicable to each rate year. In addition, the DSS Commissioner may, in the Commissioner's discretion and within available appropriations, provide pro rata fair rent increases to facilities with documented fair rent additions placed in service in the applicable cost report years (and not otherwise included in issued rates).

Finally, this Section amends Section 17b-340 to permit the DSS Commissioner to implement policies and procedures to carry out the provisions of the Section while adopting those policies and procedures as regulations, so long as the notice of intent to adopt the regulations is published no later than twenty (20) days after the implementation date.

§ 321 – Use of DSS American Rescue Plan Allocation
Effective July 1, 2021

This Section directs that the $10 million in American Rescue Plan funding allocated to DSS for nursing homes shall be used to provide temporary financial relief in the form of grant allocations based on the percent difference between the facility's issued and calculated rate. The grants will be issued on a one-time basis subject to pro rata adjustment based on available funding.

§ 323 – Wage Enhancements for Nursing Home Facility Employees
Effective June 23, 2021

This Section requires the DSS Commissioner, within available appropriations, to increase nursing home rates by 4.5% for each of FY 2022 and FY 2023, provided the rate increases are used for wage enhancements for facility employees. As stated in Section 320, facilities that receive the rate adjustment for wage enhancements but do not provide the enhancements may be subject to a rate decrease in the amount of the adjustment.

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§ 324 – Health Care and Pension Benefit Enhancements for Nursing Home Facility Employees
Effective June 23, 2021

This Section provides that the $15.4 million appropriated to DSS for Medicaid for FY 2023 shall be used to adjust nursing home rates to adjust for enhanced health care and pension benefits for facility employees. Facilities that receive a rate adjustment for providing enhanced health care and pension benefits for employees but do not provide the enhanced benefits may be subject to a rate decrease in the amount of the adjustment.

§ 326 – Co-Pay for the Connecticut Home Care for the Elderly Program
Effective July 1, 2021

This Section reduces the co-pay for the state funded portion of the Connecticut Home Care for the Elderly program from 9% to 4.5%. The Section also requires that the DSS Commissioner collect data on services provided under the program, including the estimated cost savings to the State by providing home care to participants who may otherwise receive care in a nursing home. Results of the data collection must be reported to the Aging, Appropriations and Human Services Committees of the General Assembly by July 1, 2022.

§ 338 – DSS Use of Funds Related to Medicaid and the Connecticut Home Care for the Elderly Program
Effective July 1, 2021

This Section provides more specific direction on the appropriation of $4,625,000 to DSS for Medicaid and $375,000 to DSS for the Connecticut Home Care Program for the Elderly, for the FYs ending June 30, 2022 and June 30, 2023. The funds will be used to increase the Medicaid reimbursement rate for certain Medicaid-funded home and community-based waiver program services and home health care as well as the reimbursement rate for the state-funded portion of the Connecticut Home Care Program for the Elderly. Services receiving rate increases include the Money Follows the Person Program and the Connecticut Home Care Program waiver services; only pediatric skilled nursing services in home health programs will receive a rate increase.

§ 342 – Per Diem Rate for Chronic Disease Hospitals
Effective July 1, 2021

This Section authorizes the DSS Commissioner to, within available appropriations, increase the per diem rate for chronic disease hospitals by 4%.

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II. ACTS AFFECTING NURSING HOMES AND ASSISTED LIVING

2. PUBLIC ACT 21-55. AN ACT STRENGTHENING THE BILL OF RIGHTS FOR LONG-TERM CARE RESIDENTS AND AUTHORIZING THE USE OF RESIDENT TECHNOLOGY FOR VIRTUAL VISITATION AND VIRTUAL MONITORING.
Effective July 1, 2021, except as otherwise noted

§ 1

This Section adds to the existing bill of rights for patients at a nursing home facility, an RCH or a chronic disease hospital to establish that such patients are also entitled to the right to treat one's living quarters as a home, with no fewer rights than any other resident of this State; those rights include, but are not limited to, the freedom to associate and communicate with other people privately and the right to purchase and use technology that facilitates virtual visitation, when doing so would not violate another patient's privacy rights. Patients are also entitled to the right to voice grievances and recommend policy, procedure and service changes, without restraint, interference, coercion, discrimination or reprisal from the respective facility, to the manager or staff of the nursing home facility, RCH or chronic disease hospital, government officials or any other person so designated to receive such comments or complaints. In addition, patients have the right to access representatives of DPH or the LTCO.

§ 2

This Section modifies the bill of rights for residents of managed residential communities to provide such residents with the same rights to treat their residential unit as their home on par with such rights granted to patients of nursing home facilities, RCHs and chronic disease hospitals in Section 1 of this Act.

§ 3
Effective October 1, 2021

This Section imports the definition of "nursing home facility" from existing law; it means (1) any chronic and convalescent nursing home or any rest home with nursing supervision that provides nursing supervision under a medical director twenty-four (24) hours per day or (2) any chronic and convalescent nursing home that provides skilled nursing care under medical supervision and direction to carry out nonsurgical treatment and dietary procedures for chronic diseases, convalescent stages, acute diseases or injuries.

This Section defines "resident" as a resident of a nursing home facility.

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This Section defines "resident representative" as (A) a court-appointed conservator of the person or guardian, (B) a health care representative appointed by an attested written advanced directive pursuant to current law or (C) if no such court-appointed conservator or health care representative exists, then any person who is either designated as such as evidenced by a signed written document by the resident which had been submitted to the facility for the resident's records or, in the absence of any written document, a person who is a legally liable relative or other responsible party, other than an employer or contractor of the resident's facility.

This Section defines "technology" as any device with remote audio and/or video capabilities, whether or not such device is capable of producing recordings.

This Section defines "virtual monitoring" as remote monitoring of a resident by a third party through technology owned and operated by the resident in such resident's room or living quarters.

This Section defines "virtual visitation" as remote visitation between a resident and family members or other persons with technology.

While this Act adds to the residents' bill of rights the right to use technology of one's choice to facilitate virtual monitoring or visitation, it also imposes the following restrictions, consent and notice requirements:

(1) The resident will be responsible for the expenses related to purchasing, activating, installing, maintaining, repairing, operating, deactivating and removing such technology;

(2) Any technology, recordings and images obtained through such use by the resident or any person communicating with or monitoring such resident must not violate any other person's right to privacy;

(3) A clear notice must be placed on the resident's door to indicate that technology involving virtual monitoring may be in use;

(4) In cases involving shared living situations, the resident or their representative must provide advanced notice to the roommate or the roommate's representative specifying the type of technology to be used, its proposed location and intended use, and its audio, video and remote activation capabilities along with its intended hours of operation;

(5) The resident or resident's representative must (A) obtain written consent from all roommates or their representatives for such use and (B) cease to use such technology if any roommate withdraws consent; and

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(6) A signed, written notice and a copy of any written consent of roommates must be filed with the facility no less than seven (7) days before use or installation of such technology and such notice must (A) identify the type of, intended use, hours and location of such technology, (B) state any audio, video or remote control capabilities of such technology, (C) acknowledge the resident's responsibilities as to expenses involved with such use and (D) include a waiver of all civil, criminal and administrative liability for the facility or home.

Other than the requirement that a resident's use of technology, recordings and images must not violate any other person's right to privacy, the restrictions set forth above do not apply to cellular mobile telephones mostly used for telephonic communication or tablets not used for virtual monitoring.

This Section also requires that the facility provide Internet access, electricity and power for technology used for virtual monitoring or visitation at no cost to the resident, if (A) such cost is included in cost reports filed with DSS for Medicaid reimbursement purposes, (B) such cost is eligible for reimbursement under this State's existing laws concerning long-term care, (C) DSS uses any available funding provided and authorized by the federal government for expenses related to COVID-19 if such use is approved by the federal government and (D) the facility may assess a prorated portion or unreimbursed cost to any resident privately paying for residence and using such technology. A resident also has the choice of procuring his or her own Internet and if so, will not be charged for the cost of any Internet infrastructure upgrades by the facility.

Additionally, the facility can establish policies and procedures for virtual monitoring such as (A) placement of technology devices in visible, stationary locations, (B) restrictions on the use to record outside of one's room or living quarters or shared common space, (C) compliance with life safety and fire protection requirements, (D) use limitations when it would interfere with care or privacy, unless consent is given, (E) use limitation in the event of Internet disruption and (F) actions that the facility can take for failure to comply with laws, policies or processes.

Further, this Act renders the nursing home facility immune from civil, criminal or administrative liability for (1) privacy rights violations caused by a resident's use of such technology, (2) damage to such technology and (3) inadvertent use or intentional disclosure or interception by an unauthorized third party of such technology.

This Act also requires the nursing home facility to place a notice at both its entrance and at the resident's door to indicate that technology allowing for virtual visitation or virtual monitoring may be in use, but exempts from these requirements, cellular mobile telephones used primarily for telephonic communication or tablets not used for virtual monitoring. When a roommate refuses to consent to such use, the facility must work with both the resident and the roommate to either accommodate or develop an alternative when feasible to do so. If the resident wishing to use

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technology transfers to another room due to the roommate's refusal or withdrawal of consent, the resident must pay the price differential if the accommodation results in a price that is more costly than the resident's current room.

This Section allows the LTCO to develop, in consultation with representatives of nursing home facilities and DPH, standard forms on its website for use by a resident of a nursing home facility seeking to do any of the following: (1) notify the nursing home facility that the resident plans to install and use technology for virtual monitoring; (2) procure the consent of the resident's roommate for the possible capture of such roommate's audio or video through the resident's use of virtual monitoring technology; and (3) notify the facility that the roommate has withdrawn consent to the use of the virtual monitoring technology within their residence.

Lastly, this Section also allows DPH to adopt regulations to implement the requirements of this Section.

For more information, please see the following Advisory published by Wiggin and Dana's Health Care Practice, which also addresses a related law, Public Act No. 21-160: https://www.wiggin.com/publication/connecticut-enacts-new-law-on-use-of-technology-for-virtual-visitation-and-monitoring-in-nursing-homes/.

3. PUBLIC ACT 21-71. AN ACT CONCERNING ESSENTIAL SUPPORT PERSONS AND A STATE-WIDE VISITATION POLICY FOR RESIDENTS OF LONG-TERM CARE FACILITIES.
Effective June 24, 2021

§ 1

This Section allows residents of long-term care facilities (which are defined as nursing home facilities and managed residential communities where licensed assisted living services agency services are provided) to designate a "primary essential support person" and a "secondary essential support person" who will serve as backup to the primary essential support person. The primary and secondary essential support persons may visit the resident in accordance with the rules set forth by the DPH Commissioner to provide essential support as reflected in the resident's "person-centered plan of care." A "person-centered plan of care" is defined as a care plan for a resident, developed by a resident or resident representative in consultation with health professionals which accounts for the resident's needs and includes a primary essential support person or secondary essential support person. So long as the primary essential support person (or secondary essential support person) complies with the rules promulgated by the DPH Commissioner, they may visit the resident notwithstanding any general visitation restrictions imposed on other visitors. "Essential support" includes, but is not limited to, assistance with activities of daily living and physical, emotional, psychological and socialization support for the resident.

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§ 2

This Section requires the DPH Commissioner to establish a state-wide visitation policy for long-term care facility residents. The policy must address the resident's needs for health, safety and well-being, including, but not limited to, essential support by primary or secondary essential support persons.

This Section requires that in the event of a public health emergency, the DPH Commissioner must set forth requirements for visitation with long-term care facility residents which incorporates a resident's need for essential support provided by a primary or secondary essential support person and other visitors. The requirements must include, but need not be limited to, circumstances where the facility may restrict visitors, including primary and secondary essential support persons. At a minimum, these requirements must address the following: (1) arrangements for visitation with residents through various means including outdoor visitation, virtual visitation and indoor visitation whether or not the resident is nearing end of life; (2) the resident's needs for physical, emotional, psychological and socialization support based on the resident's person-centered plan of care; (3) safety protocols for visitors in the event of communicable disease outbreaks or public health emergencies; (4) permission for the primary essential support person or the secondary essential support person to visit despite general visitation restrictions, so long as the support person complies with safety protocols established by the DPH Commissioner, and the DPH Commissioner determines that visitation will benefit the safety, health and well-being of the resident; and (5) if a resident has not designated a primary essential support person, the requirement that the long-term care facility staff work with the resident, a resident representative, a family member of the resident or the State Ombudsman to identify a primary essential support person and provide such person access to the resident.

§ 3

This Section adds some specificity to the existing duties of the LTCO concerning their duty to provide services to protect the health, safety, welfare and rights of residents by adding that these services must now include, but need not be limited to, services designed to address the impact of socialization, visitation and the role of primary or secondary essential support persons on the residents' health, safety and well-being.

4. PUBLIC ACT 21-160. AN ACT CONCERNING ACCESS TO RECORDINGS AND IMAGES FROM TECHNOLOGY USED BY NURSING HOME RESIDENTS FOR VIRTUAL VISITATION AND VIRTUAL MONITORING.
Effective October 1, 2021

This Act grants employees of nursing home facilities (defined as chronic and convalescent nursing homes and rest homes with nursing supervision) and employees of contractors providing services

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at such facilities the right to view evidence of recordings or images that is alleged to establish a basis for disciplinary action by the facility when such evidence is obtained through the resident's use of technology involving virtual visitation or virtual monitoring. A separate new law, Public Act No. 21-55, which also takes effect on October 1, 2021, authorizes nursing home facility residents to install and use technology for virtual visitation and virtual monitoring subject to certain requirements governing privacy, consent and established facility policies. This Act contains the same defined terms that are used in Public Act No. 21-55 for "resident," "resident representative," "technology," "virtual visitation" and "virtual monitoring."

Under this Act, evidence that the employee obtains based on the recordings or images must be used only for the purpose of defending against the disciplinary action. Moreover, both the nursing home facility and the employee must treat the recordings or images as confidential and must refrain from disseminating the evidence to any other person except as required by law. Any copies of the recordings or images must be returned to the resident when no longer needed to defend against the disciplinary action.

Additionally, when recordings or images taken through virtual visitation or virtual monitoring could be used to corroborate an abuse or neglect allegation, the LTCO may ask a resident about its existence without first consulting with the facility.

Further, this Act allows a resident or their representative to voluntarily release any recordings or images so long as doing so would not infringe upon another's privacy rights. The Act also establishes that the only instances where a nursing home facility, its agent or its employee, may solicit or request such recordings or images from a resident or their representative, are for the purpose of conducting investigations surrounding allegations of abuse or neglect based upon such recordings or images. If DPH initiates a complaint investigation based on a recording or image taken through virtual visitation or monitoring, DPH is authorized to provide a copy of any images or recordings to the nursing home facility that is the subject of their investigation.

5. PUBLIC ACT 21-185. AN ACT CONCERNING NURSING HOMES AND DEMENTIA SPECIAL CARE UNITS.
Effective immediately

This Act, which was referred to during the 2021 legislative session as Senate Bill No. 1030, contains several new provisions affecting nursing homes, as well as dementia special care units in assisted living facilities, that were enacted as a result of the COVID-19 pandemic and also sets forth the statutory minimum staffing requirement for nursing homes.

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§ 1 – Full-Time Infection Preventionist in Nursing Homes and Dementia Special Care Units

This Section applies to nursing homes and dementia special care units. "Nursing home" is defined as any chronic and convalescent nursing home or rest home which provides twenty-four (24) hour nursing supervision under a medical director. "Dementia special care unit" ("DSCU") is defined as a unit of an assisted living facility that locks, secures, segregates or provides a special program or unit to prevent or limit access by residents with Alzheimer's disease, dementia or other similar disorder outside the designated or separated area. A DSCU also includes any assisted living facility that advertises or markets the facility as providing specialized care for persons suffering from Alzheimer's disease or dementia.

This Section requires nursing homes and DSCUs to employ a full-time infection prevention and control specialist ("IPCS") who will be responsible for: (1) ongoing training of administrators and employees on infection prevention and control using multiple training methods, including in-person training and written materials in English and Spanish; (2) providing information on infection prevention and control both in the documentation that nursing homes or DSCUs provide to residents and posting this information in areas visible to residents; (3) participation as a member of the infection prevention and control committee ("IPCC") of the nursing home or DSCU and reporting to the committee at its regular meetings about the training provided; (4) providing training on infection prevention and control methods to supplemental or replacement staff of the nursing home or DSCU in the event that a disease outbreak or other situation reduces staffing levels; and (5) any other duties deemed appropriate by the nursing home or DSCU. The IPCS must work on a rotating schedule that ensures the IPCS covers each eight (8) hour shift at least once per month to ensure compliance with infection control standards.

§ 2 – Nursing Home and DSCU Emergency Plan of Operation

This Section requires the administrative head of each nursing home and each DSCU to provide its emergency plan of operations to the political subdivision of the state in which it is located so that the political subdivision can develop its emergency plan of operations in accordance with the Interstate Mutual Aid Compact.

§ 3 – Nursing Home Personal Protective Equipment Supply

This Section requires the administrative head of each nursing home to ensure the nursing home maintains at least a two (2) month supply of personal protective equipment for its staff and that the equipment includes various sizes to meet the staff's needs. The equipment cannot be shared between staff and may only be reused following National Center for Disease Control and Prevention strategies for optimizing personal protective equipment in health care settings. The administrative head must hold fittings for any N95 or higher rated mask at a frequency determined by DPH. This Section also requires that on or before January 1, 2022, the Department of

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Emergency Management and Homeland Security, in consultation with DPH, establish a process to evaluate, provide feedback on, approve and distribute personal protective equipment for nursing home use during public health emergencies.

§ 4 – Intravenous Line Starts in Nursing Homes

This Section requires that the administrative head of each nursing home ensure that at least one staff member or contracted professional who is licensed or certified to start an intravenous line is available on-call during each shift.

§ 5 – Nursing Home Infection Prevention and Control Committee

This Section requires each nursing home's IPCC to meet at least monthly and daily during an infectious disease outbreak so long as daily meetings do not disrupt operations of the home, in which case the IPCC should meet at least weekly. The IPCC is responsible for establishing infection prevention and control protocols and for monitoring the nursing home's IPCS. At least annually and after every disease outbreak, the IPCC must evaluate the implementation and outcome of the protocols and whether the IPCS is satisfactorily performing his or her duties.

§ 6 – Nursing Home Resident and Staff Testing During an Outbreak

This Section requires that during an infectious disease outbreak, the nursing home must test staff and residents for the infectious disease at a frequency determined by DPH based on the circumstances of the outbreak and the impact of testing on controlling the outbreak.

§ 7 – Family Councils in Nursing Homes and DSCUs

This Section requires that on or before January 1, 2022, the administrative head of each nursing home and DSCU encourage and assist in the establishment of a "family council" to facilitate and support open communication between the nursing home or DSCU and the resident's family and friends. "Family council" is defined as an independent, self-determining group of the family members and friends of the residents that is geared to meet the needs and interests of the residents and their family and friends.

§ 8 – Nursing Home Resident Care Plans

This Section requires that on or before January 1, 2022, the administrative head of each nursing home must ensure that each resident's care plan includes: (1) measures to address the resident's social, emotional and mental health needs, including opportunities for social connection and strategies to minimize isolation; (2) visitation protocols and any other relevant visitation information written in plain language and in a form that can be easily understood by residents and

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their family and friends; and (3) information on the role of the LTCO, including the contact information for the office.

The administrative head must also ensure that their staff is educated on best practices for ensuring the social, emotional and mental health needs of residents and on all components of person-centered care by January 1, 2022.

§ 9 – Amendment of Public Health Emergency Response Plan to Address Nursing Homes and DSCUs
Effective July 13, 2021

This Section requires that, on or before October 1, 2021, the Public Health Preparedness Advisory Committee must amend the plan for emergency responses to a public health emergency to include a public health emergency response plan for nursing homes, DSCUs and providers of community-based services to residents of such homes or units.

§ 10 – Nursing Home Minimum Staffing Level Requirements

This Section requires that, on or before January 1, 2022, DPH establish minimum staffing requirements for nursing homes of three (3) hours of direct care per resident, per day. DPH must also modify nursing home staffing requirements to require one full-time social worker per sixty (60) residents and to lower the current requirements for recreational staff, as deemed appropriate by the DPH Commissioner.

This Section requires the DPH Commissioner to adopt regulations to set nursing home staffing level requirements implementing the provisions of this Section.

§ 11 – Nursing Home Infrastructure Funding
Effective July 13, 2021

This Section requires DPH to seek any federal or state funds available for improvements to the infrastructure of nursing homes in the state. DPH must report on its success in accessing such funds to the General Assembly's Public Health Committee no later than January 1, 2022.

6. PUBLIC ACT 21-194. AN ACT STRENGTHENING THE VOICE OF RESIDENTS AND FAMILY COUNCILS.
Effective July 13, 2021

This Act requires state agencies to inform the LTCO and the Executive Director of the Commission on Women, Children, Seniors, Equity and Opportunity (the "Executive Director") of any legislative proposals or notice of intent to propose new or revised regulations concerning living

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and care conditions at long-term care facilities. "Long-term care facility" is defined as a chronic and convalescent nursing home, a rest home with nursing supervision or a managed residential community (where licensed assisted living services agency services are provided). The state agency must make the notification within three (3) days of submitting the proposal or posting the notice of intent on the eRegulations system. The LTCO and the Executive Director must seek testimony from the Statewide Coalition of Presidents of Residents Councils (the "Coalition") and from family member councils concerning the legislative proposal or proposed regulation.

For any proposed regulations other than emergency or technical regulations, the State Ombudsman and Executive Director must immediately inform the members of the Coalition and family councils that the agency must hold a public hearing upon request of at least fifteen (15) people within fourteen (14) days after the date that the notice of intent is posted on the eRegulations system. The agency or legislative committee in the case of a legislative proposal, must accept testimony in a way that provides for the greatest input from members of residents councils and family councils, including remote testimony when practicable and permissible.

The Act defines "residents council" as a council elected and run by residents of a long-term care facility that brings concerns about residents' living conditions and care to management of the facilities. The Act defines "family council" as a council composed of family members of long-term care facility residents that brings concerns about the residents' living conditions and care to management of the facilities.

The Act further requires any state taskforce or state agency that studies issues concerning living care or conditions at long-term care facilities to include representatives of residents' councils, representatives of family councils and chairpersons and ranking members of the General Assembly's Committee on Aging. The Act requires chairpersons of the state taskforces to schedule meetings in a way that provides for the greatest input from members of residents' councils and family councils, including remote testimony where practicable.

III. DEPARTMENT OF PUBLIC HEALTH ACTS

7. PUBLIC ACT 21-121. AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS REGARDING THE VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES.
Effective July 1, 2021, except as otherwise noted

§ 7 – Notice to Tenants About Water Supply Exceeding Maximum Contaminant Levels
Effective October 1, 2021

This Section requires the owner of any residential or commercial property to notify each tenant or lessee of any leased or rented unit located on such property whenever any testing of the water

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supply for the property indicates that the water exceeds a maximum contaminant level applicable to water supply systems for any contaminant listed in the State's regulations or for any contaminant listed on the State drinking water action level list. The owner must provide such notice to the tenant and/or lessee within forty-eight (48) hours after receipt of the results from the water testing. The local director of health is required to take all reasonable steps to verify that owners are in compliance with this Section.

§ 8 – Electronic Transmission of Nursing Home and Residential Care Home Citations
Effective October 1, 2021

This Section amends current law governing DPH's issuance of citations to nursing homes and RCHs (Conn. Gen. Stat. §19a-524) by requiring that the DPH Commissioner send a citation and notice of noncompliance either electronically in a form and manner prescribed by the Commissioner or, as required under current law, via certified mail.

§ 9 – Suspension of Criminal Background Checks in an Emergency or Significant Disruption

The Section amends current law (Conn. Gen. Stat. §19a-491c) governing the requirement that long-term care facilities (defined as including but not limited to nursing homes, RCHs, assisted living services agencies, home health agencies, hospice agencies and chronic disease hospitals) conduct criminal background checks on prospective employees with direct access to patients by permitting the DPH Commissioner to temporarily suspend the background check requirement in the event of an emergency or significant disruption. The Commissioner must inform facilities subject to the criminal background check requirement of the suspension and also inform them once the requirement is reimposed.

§§ 30-31 – Behavior Analysts Added as Mandatory Reporters for Elder Abuse
Effective October 1, 2021

These sections add behavior analysts to the list of individual practitioners required to report to DSS Elderly Protective Services when there is reasonable cause to suspect or believe that a long-term care resident (Conn. Gen. Stat. §17a-412) or elderly person (Conn. Gen. Stat. §17b-451) has been abused, neglected, exploited or abandoned.

§ 36 – Tuberculosis Screening, Testing, Treatment and Prevention for Health Care Personnel

Licensed health care institutions, including but not limited to, nursing homes, RCHs, assisted living services agencies and home health agencies must have policies and procedures in place that reflect the National Centers for Disease Control and Prevention's recommendations for tuberculosis screening, testing, treatment and prevention for health care personnel. Any employee

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providing direct patient care must receive tuberculosis screening and testing in compliance with the facility's policies and procedures, regardless of any other applicable statutes or regulations.

§ 44 – Nursing Home Administrator Licensure Examination

Previously, a person seeking a license as a nursing home administrator was required to pass an exam prescribed and administered by DPH. This Section eliminates the requirement that DPH administer the examination.

§ 45 – Categories of Licensed Health Care Institutions

This Section amends the definition of "institution" to include "hospice agency" and to remove the phrase "substance abuse treatment facility." In addition, this Section amends the definition of "assisted living services agency" to provide that in addition to being an agency that provides nursing services and assistance with activities of daily living to a population that is chronic and stable, such agency may also have a dementia special care unit or program. "Hospice agency" is defined as a public or private organization that provides home care and hospice services to terminally ill patients.

§§ 46-51, 53 – Hospice Agency Licensure and Related Provisions

In line with DPH's plan to separately license hospice agencies, these Sections amend current statutes to address hospices as separate licensed entities.

Section 46 provides that hospice agencies will now be charged for biennial licensing and inspection by the Commissioner. Hospice agencies, along with home health agencies, will be charged $100 per satellite patient service office. The Commissioner will also charge hospice agencies triennial licensing and inspection fees of $100 per satellite patient service office. The Commissioner may also require hospice agencies to meet minimum service quality standards as a condition of licensure. Persons operating a hospice agency must maintain professional liability insurance or other indemnity against professional malpractice of not less than $1,000,000 per person, per occurrence, with an aggregate of not less than $3,000,000.

Section 47 inserts "hospice agencies" and "home health aide agencies" within the definition of "long-term care facility" and Section 48 classifies a hospice agency providing services to recipients of Medicaid, Medicare or the Connecticut home care programs for the elderly as an institution subject to the State's anti-discrimination laws. The penalty for violation of such laws is suspension or revocation of the hospice agency's license.

Section 49 allows hospice agencies in rural communities unable to consistently access licensed or Medicare-certified hospice care to apply to the DPH Commissioner for a waiver from the licensing

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regulations (on par with the abilities of home health care agencies experiencing the same circumstances under existing law). Such waiver may authorize one or more of the following: (1) the agency's supervisor of clinical services to serve as the supervisor of clinical services assigned to the hospice program; (2) the hospice volunteer coordinator and the hospice program director may be permanent part-time employees; and (3) the program director may perform other services at the agency, including, but not limited to, hospice volunteer coordinator. The waiver will be effective for two (2) years and the hospice agency may reapply.

Section 50 permits nurses working at hospice agencies to administer influenza and pneumococcal vaccines to persons in their homes. In addition, Section 51 amends current law governing the ability of home health aides who are appropriately trained and certified to administer medications that are not injected by permitting a RN similarly to delegate the administration of such medications to hospice aides who also meet the required training and certification requirements. Hospice agencies must ensure that policies are in place to allow certain nursing duties to be delegated to hospice aides and ensure sufficient staffing to allow such delegation by January 1, 2022. This Section also adds the delegation of medication administration duties to hospice aides to current provisions governing liability and immunity for RNs delegating medication administration to home health aides.

Finally, Section 53 amends existing law requiring that when a hospital recommends home health care to a patient, the hospital discharge plan must also include at least two (2) options of home health care agencies. This Section requires that two (2) hospice agency options be included among those recommendations. Furthermore, currently, when a hospital owns and recommends, or receives compensation for recommending a home health care agency the hospital must disclose such ownership or investment interest to the patient when making those recommendations in a hospital discharge plan; now, they must also do so for their recommendations of hospice agencies sharing those same circumstances.

§ 52 – Orders for Home Health Care, Hospice and Home Health Aide Services

This Section provides that all home health care agency, hospice agency and home health aide agency services must be performed upon the order of a physician, licensed PA or APRN. In addition, this Section amends existing law concerning the performance of all home health care agency services to provide that to the extent such services are required to be ordered by a physician, they may also be performed upon the order of a licensed PA or APRN.

§ 54 – Suspension of Nursing Home Licensure Requirements in a Public Health Emergency

This Section permits the DPH Commissioner to suspend certain licensure requirements to allow nursing homes to provide services during a public health emergency as declared by the Governor, including provision of services in a building that is not physically connected to the nursing home

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or expansion of bed capacity in an area separate from the licensed facility. In order to provide such temporary assistance, facilities must submit an application and agree to an inspection by DPH. At a minimum, the application will require facilities to provide the following: (1) information regarding the facility's ability to sufficiently address the health, safety or welfare of such chronic and convalescent nursing home's residents and staff; (2) the address of such facility; (3) an attestation that all equipment located at such facility is maintained according to the manufacturers' specifications, and is capable of meeting the needs of such facility's residents; (4) information regarding such facility's maximum bed capacity; and (5) information indicating that such facility is in compliance with State law pertaining to the operation of such facility.

§ 55 – IV Therapy in the Nursing Home Setting

Under current law (Conn. Gen. Stat. § 19a-522f), nursing homes (both licensed chronic and convalescent nursing homes and rest homes with nursing supervision) that operate IV therapy programs may allow a PA or a RN, employed by the nursing home, to administer a peripherally inserted central catheter. This Section amends the current statute to allow a RN who is employed by a chronic and convalescent nursing home and who has been properly trained by the director of nursing or by an intravenous infusion company to (1) administer "IV therapy" or a dose of medication by intravenous injection, provided the medication is on a list of medications approved by the facility's governing body, pharmacist and medical director for intravenous injection by a RN and (2) draw blood from a central line for laboratory purposes, provided there is an agreement in place with a laboratory to process the specimens.

Chronic and convalescent nursing homes providing these services must notify the DPH Commissioner. In addition, the facility's administrator must ensure that each RN who is permitted to provide the services is appropriately trained and competent to provide these services. The nursing home administrator must maintain records of the training and competency of each RN and must make such records available for inspection by DPH upon request.

§ 56 – Assisted Living Services Agencies and Dementia Special Care Units or Programs

This Section authorizes DPH to license assisted living services agencies ("ALSAs") and provides that any managed residential community wishing to provide assisted living services must become licensed as an ALSA or arrange to have assisted living services provided by another agency licensed as an ALSA. A managed residential community intending to arrange for assisting living services can only do so with a currently licensed ALSA, and such arrangement must be requested through submission of an application on a form provided by DPH.

This Section also sets forth a new requirement that any ALSA providing services as a "dementia special care unit or program" must obtain approval for the unit or program from DPH and ensure proper staffing is provided to meet the residents' needs. Any ALSA providing dementia special

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care unit or program services must submit a list of dementia special care units or locations and their staffing plans for the units and locations when completing an initial or renewal licensure application. This list must also be made available to DPH upon request.

The ALSA must ensure that all services being provided on an individual basis to clients are fully understood and agreed upon by either the client or the client's representative and that the client or their representative are made aware of the cost of such services.

§ 57 – Bed Clearance Requirements

This Section applies to chronic and convalescent nursing homes, chronic disease hospitals associated with a chronic and convalescent nursing home, rest homes with nursing supervision and RCHs. It amends current law to require that the facility position beds in a manner that promotes resident care and provides at least a three-foot clearance at the sides and foot of each bed. The bed must not act as a restraint on the resident, create a hazardous situation, including but not limited to an entrapment possibility or obstacle to evacuation or be close to or blocking a heat source. The bed position must also allow for infection control.

§ 89 – Obligation of Health Care Institutions to Obtain Potable Water
Effective October 1, 2021

This Section provides that health care institutions required to obtain a potable water supply as a temporary measure to alleviate a water supply shortage must obtain the potable water from a licensed bulk water hauler or a "bottler." A "bottler" is any person, firm or corporation engaging in the business of bottling or distributing water for sale or distribution.

§§ 91-92 – Dementia Special Care Unit or Program
Effective July 6, 2021

These Sections provide for technical and conforming changes to existing laws (Conn. Gen. Stat. §§19a-562 and 19a-562a) setting forth disclosure and training requirements for Alzheimer's special care units or programs at nursing homes, RCHs, assisted living facilities, adult congregate living facilities, adult day care centers, hospices or adult foster homes to replace the term "Alzheimer's" with "dementia" and to replace the phrase "Alzheimer's special care unit or program" with "dementia special care unit or program." No substantive changes were made to existing law by this Section.

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8. PUBLIC ACT 21-196. AN ACT CONCERNING PHYSICIAN ASSISTANTS.
Effective October 1, 2021

This Act amends various sections of existing law to allow PAs to certify, sign or otherwise document medical information in various situations that currently require the signature, certification or documentation of a licensed physician or APRN. Examples include:

- certifying the need of designated beneficiaries so that such individuals can withdraw funds from the Connecticut Home Care Trust Fund to use for qualified home care expenses which was established under the Connecticut Homecare Option Program for the Elderly and allows individuals to plan for the cost of services that will enable them to remain in their homes or in a noninstitutional setting as they age;

- providing the certificate required when a nursing home resident is incapable of caring for him or herself and has no legal representative and there is a need to extend the timeframe to request undue hardship relief when a Medicaid eligibility penalty is imposed so that a legal representative can be appointed to act on the resident's behalf;

- certifying a disability or illness for continuing education waivers or extensions for various health professions;

- documenting the basis for a nursing home transfer or discharge of a resident and developing the resident's discharge plan to effectuate such transfer or discharge;

- documenting situations referenced as "medically contraindicated" in the nursing home residents bill of rights statute, Conn. Gen. Stat. §19a-550;

- along with physicians and APRNs, being required to notify a patient's health care representative, conservator, designated representative or next-of-kin within a reasonable time prior to withholding or causing the withdrawal of any life support system;

- expanding the definition of "home health care" for insurance cases where home health care is provided by recognized non-medical systems to now include the continued care and treatment by a PA and allow for PAs to diagnose a terminal illness and approve a home health care plan;

- providing that the hiring of a PA can now satisfy the staffing requirement for a facility to be recognized as a home health agency and that such PA may provide full time supervision of the home health agency services and may prescribe medicine at the home health agency;

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- adding PAs to the list of providers (1) who must report when a patient has tuberculosis and (2) to whom local health directors, in turn, must provide certain information for these patients;

- providing that comprehensive rehabilitation services can consist of a plan approved by a PA and reviewed every thirty (30) days by the PA in accordance with existing law to determine if such services are medically necessary and allowing PAs to prescribe supplies and services as part of such plan;

- certifying that services are medically necessary to ensure that a Medicare supplement policy covers the services; and

- authorizing PAs to make various diagnoses and certify patients' health conditions and related information for the purposes of insurance coverage.

IV. ACTS CONCERNING EMPLOYMENT

9. PUBLIC ACT 21-1. AN ACT CONCERNING RESPONSIBLE AND EQUITABLE REGULATION OF ADULT-USE CANNABIS.

§§ 97-101
Effective July 1, 2022

This lengthy Act legalizes the adult-use of marijuana in this State. This summary focuses on sections of the Act relevant to long-term care providers as employers. These sections allow all employers to continue to enforce drug-free workplaces and respect the need for employers to maintain workplace safety and to remain in compliance with federal laws and contracts. Under the Act, certain employers and positions are exempt from complying with provisions of this Act, including those that prohibit discharge or other adverse actions against employees or prospective employees for possession and use of cannabis outside the workplace. As such, employers in certain industries, such as health care and social services, are considered "exempt" from some employment provisions of this Act. This Act does not prohibit any employer, including an employer that is not exempt, from taking adverse actions against employees who are impaired at work. Of note, the Act includes within its provided definition of "exempted position," those that require workers to supervise medical patients or vulnerable persons, among other positions. In addition, the term "employee" includes an independent contractor.

For more information, please see the following Advisory published by Wiggin and Dana's Labor, Employment and Benefits Department, at https://www.wiggin.com/publication/what-connecticut-employers-need-to-know-about-the-cannabis-legislation/.

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10. PUBLIC ACT 21-2. AN ACT CREATING A RESPECTFUL AND OPEN WORLD FOR NATURAL HAIR.
Effective March 4, 2021

Commonly known as the Crown Act ("Creating a Respectful and Open World for Natural Hair"), this Act bans natural hair discrimination in the workplace (as well as in housing, public accommodations and other contexts) by broadening the State's anti-discrimination statute to now define "race" as "inclusive of ethnic traits historically associated with race, including, but not limited to, hair texture and protective hairstyles." The Act provides that the term "protective hairstyles" "includes, but is not limited to, wigs, headwraps and hairstyles such as individual braids, cornrows, locs, twists, Bantu knots, afros and afro puffs." This Act has the effect of requiring employers to ensure that their dress code and/or grooming policies do not prohibit protected hairstyles or traits historically associated with race.

11. PUBLIC ACT 21-30. AN ACT CONCERNING THE DISCLOSURE OF SALARY RANGE FOR A VACANT POSITION.
Effective October 1, 2021

This Act amends existing law prohibiting employers from penalizing employees for discussion or disclosure of wage information to now require employers to provide job applicants and employees with a "wage range" for their positions. The Act defines "wage range" as the range of wages the employer anticipates relying on when setting wages for a position; this may include reference to any applicable pay scale, previously determined wage ranges for the position, actual wage ranges for current employees or the employer's budgeted amount for the position. This Act also modifies existing law concerning prohibited practices and discrimination on the basis of sex in the workplace to include new language requiring employers to provide employees with equal pay for "comparable" work, as opposed to "equal" work.

For more information on this Public Act 21-30, please see the summary prepared by Wiggin and Dana LLP's Labor, Employment and Benefits Department, at https://www.wiggin.com/publication/connecticut-wage-law-amended-to-require-disclosure-of-wage-ranges-and-change-pay-equity/.

12. PUBLIC ACT 21-69. AN ACT DETERRING AGE DISCRIMINATION IN EMPLOYMENT APPLICATIONS.
Effective October 1, 2021

This Act amends existing law governing discrimination in employment to address age discrimination in the employment application process. The Act prohibits an employer from requesting or requiring a prospective employee's age, date of birth, dates of attendance at or date of graduation from an educational institution on an initial employment application. These

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restrictions do not apply to an employer requesting or requiring such information (i) based on a bona fide occupational qualification or need or (ii) when the information is required to comply with any provision of state or federal law.

For more information on Public Act 21-69, please see the summary prepared by Wiggin and Dana LLP's Labor, Employment and Benefits Department, at https://www.wiggin.com/publication/connecticut-prohibits-age-related-inquiries-on-employment-applications/.

13. PUBLIC ACT 21-107. AN ACT EXPANDING WORKERS' COMPENSATION BENEFITS FOR CERTAIN MENTAL OR EMOTIONAL IMPAIRMENTS SUFFERED BY HEALTH CARE PROVIDERS IN CONNECTION WITH COVID-19.
Effective June 30, 2021

§ 1

This Section amends the state Workers' Compensation Act to expand workers' compensation benefits for certain mental or emotional impairments suffered by health care providers and other "eligible individuals" based on a diagnosis of "post-traumatic stress injury" related to COVID-19.

§ 2

This Section defines "eligible individuals" as police officers, firefighters, emergency medical services personnel, Department of Correction employees, telecommunicators and health care providers and updates the term "post-traumatic stress disorder" to "post-traumatic stress injury."

In addition, this Section expands the definition of "qualifying events" that would make a diagnosis of a post-traumatic stress injury compensable for eligible individuals. "Qualifying event" now includes an event arising out of and in the course of employment on or after March 10, 2020, in which an eligible individual who is a health care provider is engaged in activities substantially dedicated to mitigating or responding to the COVID-19 public health emergency and civil preparedness emergencies declared by the Governor. "COVID-19" is defined in this Section as the respiratory disease designated by the WHO on February 11, 2020, as coronavirus 2019, and any related mutations recognized by the WHO as a communicable respiratory disease.

Furthermore, qualifying events relating to COVID-19 includes situations in which the health care provider: (i) witnesses a person's death due to or later found to be caused by COVID-19; (ii) witnesses an injury to a person who later dies due to COVID-19 or as a result of symptoms later diagnosed as COVID-19; (iii) has physical contact with and cares for a person who subsequently dies because of COVID-19 or due to symptoms later found to be COVID-19; or (iv) witnesses a

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traumatic physical injury that results in the loss of a vital body function due to COVID-19 or from symptoms that were later diagnosed as COVID-19.

Of note, this Section defines a "health care provider" to include people employed at a nursing home, nursing facility, retirement facility or home health care provider, as well as those employed at a doctor's office, hospital, health care center, clinic, medical school, local health department or agency, any facility performing laboratory or medical testing, pharmacy or similar institution. It also includes a person employed to provide personal care assistance, provided such person is regularly employed by the owner or occupier of the dwelling for more than twenty-six (26) hours per week.

This Section also makes various technical and conforming changes.

14. PUBLIC ACT 21-200. AN ACT RESTRUCTURING UNEMPLOYMENT INSURANCE BENEFITS AND IMPROVING FUND SOLVENCY.
Effective January 1, 2022

This Act modifies existing law concerning the State's UI system for implementation on January 1, 2024. For UI benefits, among other things, the new law generally (1) increases the minimum weekly UI benefit from $15 to $40 and correspondingly increases the minimum earnings needed to qualify for the minimum benefit from $600 to $1,600 and (2) freezes the maximum benefit allowed from 2024 through 2027. For UI taxes paid by employers, among other things, the law (1) increases employers' taxable wage base from $15,000 to $25,000 per employee and requires it to be annually adjusted for inflation; (2) removes the current employers' charged tax rate table and expands the range of employers' charged tax rates from 0.5% – 5.4% to 0.1% – 10%; and (3) generally reduces the maximum fund balance rate from 1.4% to 1.0%.

This Act also provides that, by January 1, 2024, no base period employer's account shall be charged regarding benefits to a claimant through the voluntary shared work unemployment compensation program if the claim for benefits is filed during a week where the average total unemployment in this State equals or exceeds 6.5% based on the most recent three (3) months of data published by the Labor Commissioner. The Labor Commissioner may also decide that no base period employer's account be charged for benefits paid to a claimant through the voluntary shared work unemployment compensation program if filed during a week where average unemployment rates in this State equals or exceeds 8% based on the most recent one (1) month of data published by the Labor Commissioner.

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V. MISCELLANEOUS ACTS OF INTEREST

A. TELEHEALTH

15. PUBLIC ACT 21-9. AN ACT CONCERNING TELEHEALTH.
Effective May 10, 2021

§ 1

I. Section 1(a) defines "telehealth" as the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical, oral and mental health, and includes interaction between the patient at the originating site and the telehealth provider at a distant site, synchronous interactions, asynchronous store and forward transfers or remote patient monitoring. Telehealth does not include interaction through (a) facsimile, texting or electronic mail, or (b) audio-only telephone unless the telehealth provider is (i) in-network or (ii) a provider enrolled in the Connecticut medical assistance program providing such health care or other health services to a Connecticut medical assistance program recipient.

In addition, Section 1(a) defines "telehealth provider" as any person who is (A) an in-network provider or a provider enrolled in the Connecticut Medical Assistance Program and providing health care to a Connecticut medical assistance program recipient through the use of telehealth within such person's scope of practice and in accordance with the standard of care applicable to such person's profession, and (B) is one of the following Connecticut-licensed practitioners:

- Physicians
- Physician assistants
- Physical therapists
- Physical therapist assistants
- Chiropractors
- Naturopaths
- Podiatrists
- Occupational therapists
- Occupational therapy assistants
- Optometrists
- Registered nurses
- Advanced practice registered nurses
- Psychologists

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- Marital and family therapists
- Clinical social workers
- Master social workers
- Alcohol and drug counselors
- Professional counselors
- Dietitian-nutritionists
- Speech and language pathologists
- Respiratory care practitioners
- Audiologists
- Pharmacists
- Paramedics
- Nurse-midwives
- Dentists
- Behavior analysts
- Genetic counselors
- Music therapists
- Art therapists
- Athletic trainers

The definition of "telehealth provider" also includes the above types of practitioners who do not hold a Connecticut license, provided that the practitioner (1) is licensed or certified in another state or territory of the United States or the District of Columbia; (2) is authorized to practice telehealth under any relevant order issued by DPH; and (3) maintains professional liability insurance, or other indemnity against liability for professional malpractice in an amount that is equal to or greater than that required for similarly licensed, certified or registered Connecticut health care providers.

II. Section 1(b) establishes the following requirements for telehealth providers, for the time period from May 10, 2021 and ending July 30, 2023:

1. Preliminary requirements. A telehealth provider may only provide telehealth services to a patient when the provider:

    1. Is communicating through real-time, interactive, two-way communication technology or store and forward transfer technology;

    2. Has determined whether the patient has health coverage and whether the patient's health coverage, if any, provides coverage for the telehealth services;

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3. Has access to, or knowledge of, the patient's medical history, as provided by the patient, and the patient's health record, including the name and address of the patient's primary care provider, if any;

4. Conforms to the standard of care applicable to the profession and expected for in-person care as appropriate to the patient's age and presenting condition (note that where the standard of care requires diagnostic testing and a physical examination, the testing or examination may be carried out through the use of peripheral devices appropriate to the patient's condition); and

5. Provides the patient with the provider's license number, if any, and contact information.

2. Notice and consent. At the time of the first telehealth interaction, telehealth providers are required to inform the patient concerning the treatment methods and limitations of treatment using a telehealth platform, including, but not limited to, the limited duration of the Act's provisions (through June 30, 2023). After providing the patient with this information, the telehealth provider must obtain the patient's consent to provide telehealth services. The notice and consent must be documented in the patient's medical record and any subsequent revocation of consent must be documented as well. Any consent or revocation must be obtained from the patient, the legal guardian, conservator or other authorized representative, as applicable.

3. Disclosure of records to primary care provider. Also, at the time of the first telehealth interaction, telehealth providers are required to ask if the patient consents to the provider's disclosure of records pertaining to the telehealth interaction to the patient's primary care provider. If consent is obtained, the telehealth provider must provide the records to the primary care provider, in accordance with Connecticut law.

4. Prescribing practices. Telehealth providers may not prescribe, through the use of telehealth, any schedule I, II or III controlled substance; however, schedule II or III controlled substances, other than an opioid drug, may be prescribed for the treatment of a person with a psychiatric disability or substance use disorder in a manner fully consistent with the Ryan Haight Online Pharmacy Consumer Protection Act. Any schedule II or III controlled substance that is prescribed must be electronically submitted pursuant to Connecticut law.

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5. HIPAA compliance. Telehealth providers must continue to act in compliance with HIPAA, as applicable, but may utilize "any information and communication technology consistent in accordance with the directions, modifications or revisions," to HIPAA that are made by the Office for Civil Rights of the United States Department of Health and Human Services ("OCR"), the federal agency that enforces HIPAA. This language is consistent with a prior executive order, Executive Order 7G, and ensures that providers can take advantage of the OCR notification of enforcement discretion stating that during the COVID-19 nationwide public health emergency, penalties for HIPAA violations will be waived for "health care providers that serve patients in good faith through everyday communications technologies," such as Apple FaceTime, Facebook Messenger video chat, Google Hangouts video or Skype.

6. Prohibition on facility fees. Telehealth providers may not charge a facility fee for telehealth services. Facility fee is defined as any fee that is distinct from a professional fee that is charged or billed by a hospital or health system for outpatient services provided in a hospital-based facility that is intended to compensate the hospital or health system for the operational expenses of the hospital or health system.

7. Payment. If the telehealth provider determines that the patient does not have health coverage for telehealth services, then the provider must accept as payment in full for the telehealth services, an amount equal to the amount that Medicare reimburses for such services. However, if the telehealth provider determines that the patient has health coverage for telehealth services, then the provider must accept as payment in full for the telehealth services the amount that the patient's health coverage reimburses, and any coinsurance, copayment, deductible or other out-of-pocket expense imposed by the patient's health coverage. If a telehealth provider determines that the patient cannot pay for telehealth services, the provider must offer financial assistance, if the provider is otherwise required to offer financial assistance under any applicable state or federal law.

8. Location. A telehealth provider may provide telehealth services, in accordance with the Act's provisions, from any location. Public Act 21-133, effective July 7, 2021, revised this provision, subjecting it to compliance with all applicable federal requirements. In addition, the location provision is notwithstanding any provision of the general statutes, and, per Public Act 21-133, any provision of the state licensing standards.

9. Verification of out-of-state providers. Any Connecticut entity, institution or provider that engages or contracts a telehealth provider licensed in another state to provide

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telehealth services, must verify the out-of-state provider's credentials, ensure that the provider is in good standing in that state and confirm that the provider maintains the requisite amount of appropriate insurance or other indemnity against liability for professional malpractice.

In addition, the Act makes clear that it does not prohibit providers from (1) providing on-call coverage pursuant to an agreement with another provider; (2) consulting with another health care provider concerning a patient's care; (3) ordering care for hospital outpatients or inpatients; or (4) using telehealth for a hospital inpatient, including for the purpose of ordering medication or treatment for such patient, in accordance with applicable law.

Lastly, the Commissioner of DPH is authorized to temporarily waive, modify or suspend any regulatory requirements, as the Commissioner deems necessary to reduce the spread of COVID-19 and to protect public health for the purpose of providing Connecticut residents with telehealth services from out-of-state practitioners.

§ 2

Section 2 repeals and replaces CGS § 21a-249(c), which addresses circumstances under which a licensed practitioner is not required to electronically transmit a prescription to a pharmacy. The revised language appears in CGS § 21a-249(c)(5), which says that a practitioner does not have to electronically transmit a prescription to a pharmacy if he or she demonstrates that he or she does not have the technological capacity to issue electronically transmitted prescriptions. The newly added language says that the provisions of CGS § 21a-249(c)(5) do not apply to practitioners prescribing as a telehealth provider, as defined in Section 1 of the Act (as set forth in Section I above), that are prescribing pursuant to the prescribing practices detailed in Section II(4) above.

§§ 3-4

Sections 3 and 4 impose telehealth payment requirements on health insurers, specifically individual and group health insurance policies that provide coverage for (1) basic hospital expense coverage; (2) basic medical-surgical expense coverage; (3) major medical expense coverage; (4) hospital or medical service plan contract; or (5) hospital and medical coverage provided to subscribers of a health care center.

Any such policies must provide insurance coverage for telehealth services, to the same extent that coverage is provided for such services when provided to the insured in-person.

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§ 5

Health insurers are prohibited from reducing the amount of reimbursement paid to a telehealth provider for telehealth services merely because the telehealth provider provided the services through telehealth.

§ 6

The Commissioner of DSS is authorized to provide coverage under Connecticut Medicaid and/or the Children's Health Insurance Program for audio-only telehealth services for the period beginning on May 10, 2021 and ending on June 30, 2023. Public Act 21-133 added language to Section 6 providing that such authorization to make the coverage determination may only take place when (1) clinically appropriate, as determined by the Commissioner; (2) it is not possible to provide comparable covered audiovisual telehealth services and (3) provided to individuals who are unable to use or access comparable, covered audiovisual telehealth services. Public Act 21-133 also added language that, to the extent permissible under federal law, the Commissioner shall provide Medicaid reimbursement for services provided via telehealth to the same extent as if the service was provided in person.

§ 7

This Section permits a physician or APRN to issue a written certification to a qualifying patient for medical marijuana and provide any follow-up care for such a patient using telehealth services during the period beginning on May 10, 2021 and ending on June 30, 2023, provided all other requirements for issuing the written certification to the qualifying patient and all recordkeeping requirements are satisfied.

For more information, please see the following Advisory published by Wiggin and Dana's Health Care Practice, at https://www.wiggin.com/publication/new-connecticut-law-extends-telehealth-flexibility-and-mandates-insurance-payment-parity-for-telehealth-services/.

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B. HOME HEALTH

16. PUBLIC ACT 21-133. AN ACT CONCERNING HOME HEALTH, TELEHEALTH AND UTILIZATION REVIEW.
Effective July 7, 2021

§ 1

Section 1 repeals and replaces CGS § 17b-242, which addresses payments to home health care agencies and home health aide agencies by adding a new section (h) addressing orders for Medicaid home health care services. This new section allows for any order for home health care services covered by DSS to be issued by any licensed practitioner authorized to issue such an order pursuant to CGS § 19a-496a, as amended by the Act (see Section 2 below). In addition, any DSS regulation, policy or procedure that applies to a physician who orders such services, including related provisions such as review and approval of care plans for home health care services, will apply to any licensed practitioner authorized to order such services pursuant to CGS § 19a-496a, as amended by the Act (see Section 2 below).

§ 2

Section 2 repeals and replaces CGS § 19a-496a, which addresses home health care agency services ordered by a provider licensed in a state which borders Connecticut. The statute previously said that all home health care agency services that are required by law to be performed upon the order of a physician may be performed upon the order of a physician licensed in a state which borders Connecticut. The statute is revised as follows:

1. All home health care agency, hospice home health care agency or home health aide agency services will be performed upon the order of a physician, PA or APRN, all of whom must be licensed pursuant to Connecticut law.

2. All home health care agency, hospice home health care agency and home health aide agency services that are required by law to be performed upon the order of a physician, PA or APRN, may be performed upon the order of any of these practitioners licensed in a state which borders Connecticut. Any DPH agency regulation, policy or procedure that applies to a physician who orders home health care services, including related provisions such as review and approval of care plans for home health care services, shall also apply to an APRN or PA who orders such services.

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§ 3

Section 3 repeals and replaces subsection (j) of Section 1 of Public Act 21-9, which previously said that notwithstanding any provision of the general statutes or any regulation adopted thereunder, a telehealth provider may provide telehealth services pursuant to the provisions of Public Act 21-9 from any location. The revised language says that subject to compliance with all applicable federal requirements, notwithstanding any provision of the general statutes, state licensing standards or any regulation adopted thereunder, a telehealth provider may provide telehealth services pursuant to that Section 1 of Public Act 21-9 from any location.

§ 4

Section 4 repeals and replaces Section 6 of Public Act 21-9, which previously said that notwithstanding the provisions of CGS §§ 17b-245c, 17b-245e or 19a-906, or any other section, regulation, rule, policy or procedure governing the Connecticut medical assistance program, the Commissioner of DSS is authorized to provide coverage under Connecticut Medicaid and/or the Children's Health Insurance Program for audio-only telehealth services for the period beginning on May 10, 2021 and ending on June 30, 2023. The revised Section 6 largely retains the original language and adds that the Commissioner is authorized to make such coverage determination when (1) clinically appropriate, as determined by the Commissioner, (2) it is not possible to provide comparable covered audiovisual telehealth services and (3) provided to individuals who are unable to use or access comparable, covered audiovisual telehealth services. In addition, it also adds language that to the extent permissible under federal law, the Commissioner shall provide Medicaid reimbursement for services provided via telehealth to the same extent as if the service was provided in person.

§ 5

Section 5 authorizes the Commissioner of DSS to waive or suspend, in whole or in part, as the Commissioner deems necessary, any prior authorization or other utilization review criteria and procedures for Connecticut Medicaid and/or the Children's Health Insurance Program. The Commissioner shall include notice of any waiver or suspension in a provider bulletin sent to affected providers and posted on the Connecticut Medicaid and/or Children's Health Insurance Program website not later than fourteen (14) days prior to implementing such waiver or suspension.

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C. STATE BONDS

17. PUBLIC ACT 21-111. AN ACT AUTHORIZING AND ADJUSTING BONDS OF THE STATE FOR CAPITAL IMPROVEMENTS, TRANSPORTATION AND OTHER PURPOSES, ESTABLISHING THE COMMUNITY INVESTMENT FUND 2030 BOARD, AUTHORIZING STATE GRANT COMMITMENTS FOR SCHOOL BUILDING PROJECTS AND MAKING REVISIONS TO THE SCHOOL BUILDING PROJECT STATUTES.
Effective July 1, 2021, except as otherwise noted

§§ 8-9 – DOH Funding and Terms of its Use for FY 2022

This Act permits the State Bond Commission to authorize the issuance of state bonds in one or more series and in principal amounts in the aggregate, not exceeding $100,000,000, for use by DOH in FY 2022. An unspecified portion of the $100,000,000 proceeds from the state bond issuances must be used by DOH for, among other things, housing development and rehabilitation, including moderate cost housing, moderate rental, congregate and elderly housing, urban homesteading, community housing development corporations, housing purchase and rehabilitation and housing for low-income persons including loan guarantees for private developers of rental housing for the elderly and affordable housing projects.

§§ 12-13 – Grants-in-Aid and Other Project Financing for FY 2022

This Act also permits the State Bond Commission to authorize the issuance of state bonds in one or more series and in principal amounts in the aggregate, not exceeding $304,150,000, to be used by state agencies such as OPM and DPH, nonexclusively, for the purpose of providing grants-in-aid and other financing for projects, programs and purposes which include, among other things:

- Grants for private, nonprofit health and human service organizations that are exempt under Section 501(c)(3) of the IRC, and receive state funds to provide direct health or human services to state agency clients, for alterations, renovations, improvements, additions and new construction, including (A) health, safety, Americans with Disabilities Act compliance and energy conservation improvements; (B) information technology systems; (C) technology for independence; and (D) vehicle purchases and property acquisition not exceeding $10,000,000; and

- Grants for the Health Disparities and Prevention Grant Program, not exceeding $40,000,000, provided that: (1) no more than $25,000,000 is used for federally qualified health centers and not more than $300,000 of such amount may be used to conduct a health disparities study; and (2) no more than $15,000,000 is used for mental health and substance abuse treatment providers.

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§§ 27-28 – DOH Funding and Terms of its Use for FY 2023
Effective July 1, 2022

This Act also reauthorizes the State Bond Commission to issue state bonds in one or more series and in principal amounts in the aggregate, not exceeding $100,000,000, in FY 2023 for use by DOH for those same purposes as described above for Sections 8-9 in FY 2022.

§§ 31-32 – Grants-in-Aid and Other Project Financing for FY 2023
Effective July 1, 2022

This Act permits the State Bond Commission to authorize the issuance of state bonds in one or more series and in principal amounts in the aggregate, not exceeding $263,550,000, in FY 2023 for use by state agencies such as OPM and DPH, nonexclusively, for the purpose of providing grants-in-aid and other financing for the same projects, programs and purposes as described above in Sections 12 and 13 of the Act. Notable differences with the FY 2023 funding is that OPM is authorized to use up to $25,000,000, instead of just $10,000,000, for grants for private, nonprofit health and human service organizations that are exempt under Section 501(c)(3) of the IRC and there is no stated appropriation and cap for a health disparities study.

§ 112 – Use of Funds from the State's Economic Action Plan
Effective June 30, 2021

This Section establishes that for FY 2022, and each FY thereafter, $125,000,000 of the funds available for the purposes of the State's Economic Action Plan shall be reserved for (A) projects that provide (i) a revolving loan program, microloans or gap financing, to women or minority-owned small businesses, (ii) start-up funds to establish women or minority-owned small businesses, (iii) brownfield remediation or broadband expansion, (iv) human services, workforce development, mental health services, educational programming, pre-apprenticeship and apprenticeship training, youth services programming or physical, intellectual and developmental disability services; (B) projects that provide the potential to directly impact community enrichment programs for or related to, financial literacy, home ownership opportunity, free or reduced tuition for vocational training schools, academic scholarships, seniors' and veterans' services and arts and culture; or (C) projects that provide the potential to directly impact youth and adult enrichment programs for or related to, "earn while you learn" programs, paid internships or summer youth programming.

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D. DEPARTMENT OF SOCIAL SERVICES/HUMAN SERVICES

18. PUBLIC ACT 21-148. AN ACT CONCERNING REVISIONS TO PROVISIONS OF THE GENERAL STATUTES AFFECTING THE DEPARTMENT OF SOCIAL SERVICES AND A STUDY OF PAYMENT PARITY FOR HUMAN SERVICES PROVIDERS.
Effective as noted

§ 11
Effective July 7, 2021

This Section requires the Commissioner of DSS in collaboration with the Commissioners of Mental Health and Addition Services and Housing to study whether State contracted providers of "human services" receive disparate pay rates under programs administered by the Commissioners in different regions of this State. By November 1, 2021, the Commissioners must produce a report on their rate study and provide recommendations for rate adjustments to the Joint Committees on Appropriations and Budgets, Housing, Human Services and Public Health. "Human services" as defined in this Section includes physical and behavioral health services as well as housing and shelter services for homeless persons.

E. BEHAVIORAL HEALTH

19. PUBLIC ACT 21-35. AN ACT EQUALIZING COMPREHENSIVE ACCESS TO MENTAL, BEHAVIORAL AND PHYSICAL HEALTH CARE IN RESPONSE TO THE PANDEMIC.
Effective June 14, 2021

§ 1

This Section declares that racism is a public health crisis in this State and will remain one until the goal of attaining at least a 70% reduction in the racial disparities in education, health care, criminal justice and economics are met.

§ 2

This Section establishes a Commission on Racial Equity in Public Health (the "Commission") to document and make recommendations to decrease the effects of racism on public health. This Section provides a list of individuals who will serve as the members of the Commission. The Commission members include individuals appointed by the House, Senate and the Governor; chairpersons of specific organizations; members of specific community organizations and caucuses; commissioners and secretaries of state departments and offices; and executive officers and directors of state organizations. The appointments of members must be made within sixty (60) days of the effective date of this Section. If appointments are not made within the sixty (60) day

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period, then the chairpersons may designate qualified individuals to serve until appointments are made in accordance with this Section. This Section also provides additional provisions addressing the length of appointed member terms, procedures for filling vacancies, procedures for quorum votes, rules on member compensation and the procedure for hiring an executive director for the Commission.

The Commission will have the following powers and duties: (1) support collaboration between different sectors to recognize the link between health and other policy issues and build new partnerships to promote health and equity and increase government efficiency; (2) create a comprehensive strategic plan to eliminate health disparities and inequities across sectors; (3) study the impact that racism has on vulnerable populations within diverse groups of the State population including on the basis of race, ethnicity, sexual orientation, gender identity and disability; (4) obtain from any legislative or executive department, board, commission or other entity such assistance as necessary to carry out the purposes of this Section; (5) accept any gift, donation or bequest for the purpose of performing the duties of this Section; (6) establish bylaws to govern procedures; and (7) perform other acts as may be necessary to carry out the duties of this Section.

This Section also requires the Commission to engage with community members who identify as members of diverse groups of the state population, based on race, ethnicity, sexual orientation, gender identity and disability, who experience inequities in health. The Commission will engage with these members to make ongoing recommendations to state agencies on the following issues: (1) structural racism in state laws and regulations that impact public health; (2) the impact of racial disparities in the criminal justice system on the health and well-being of individuals and families; (3) racial disparities in access to necessary resources for healthy living; (4) racial disparities in health outcomes; (5) the impact of zoning restrictions on housing disparities and public health; (6) racial disparities in hiring and contracting processes; and (7) any other suggestions to reduce the impact of racism within vulnerable populations.

"Structural racism" is defined as a system that structures opportunity and assigns value in a way that disproportionately and negatively impacts Black, Indigenous, Latino or Asian people or other people of color.

This Section also requires the Commission to submit a report to the Secretary of OPM and the Joint Committees on Public Health and Appropriations on the activities of the Commission, any progress made in attaining the goal, any recommended changes to the goal, the status of the comprehensive strategic plan and any recommendations for policy changes or state law amendments.

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§ 3

This Section requires the Commission to develop and periodically update a comprehensive strategic plan to eliminate health disparities and inequities across sectors and declares the State's goal to attain at least a 70% reduction in the racial disparities identified in the comprehensive plan. This plan must include consideration of, among others, the sectors of public health, access to quality health care and social services. The plan must address the incorporation of health equity into policies, programs and government decision making processes including, among others, disparities in public health laws and regulations and disparities in access to quality health care.

As a part of the comprehensive plan, by January 1, 2022, the Commission must use available scientifically based measurements to determine the percentages of racial disparity in various areas, among which, of relevance, concerns the disparity in health care utilization and outcome indicators, including health insurance coverage rates, emergency room visits and deaths related to conditions associated with exposure to environmental pollutants including respiratory ailments, quality of life, life expectancy, lead poisoning and access to adequate healthy nutrition and self-reported well-being surveys. After completion of the plan and after any update, the Commission must submit the plan to the Joint Committee on Public Health and to any other joint committee as determined by the Commission.

§ 4

This Section requires the Commission to determine best practices for state agencies to evaluate structural racism within their own policies, practices and operations and to create and implement a plan that includes the establishment of benchmarks for improvement to eliminate any structural racism within the respective state agency.

The Commission must submit a report by January 1, 2023 to the Joint Committee on Government Administration that includes the best practices established by the Commission and recommendations on legislation to implement those practices.

§ 5

This Section requires the Commissioner of DPH to study the development and implementation of a recruitment and retention program for health care workers of color. The Commissioner must report the results of the study by February 1, 2022 to the Joint Committee on Public Health. The report must include any legislative recommendations to improve recruitment and retention of individuals of color in the health care sector and recommendations for the implementation of such recruitment and retention program.

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§ 10

This Section requires DPH to conduct a study of the State's COVID-19 response. The Commissioner is required to submit a preliminary report on the findings of the study to the Joint Committee on Public Health by February 1, 2022. The report may include recommendations for policy changes to improve the State's response to future pandemics and how to improve the administration of mass vaccinations, reporting and utilization of personal protective equipment during a public health emergency, cluster outbreak investigation and health care facilities' care for patients.

§ 11

This Section requires any state agency, board or commission that collects, directly or through contract, demographic data about ancestry, ethnic origin, ethnicity, race or primary language of residents of this State in the context of health care or any public health purpose to comply with the requirements for the collection of such data.

The requirements include the following: (1) collect data in a matter that allows aggregation and disaggregation; (2) expand race and ethnicity categories to include subgroup identities specified by the Community and Clinical Integration Program of OHS and follow the hierarchical mapping to align with the U.S. Office of Management and Budget standards; (3) provide the option for individuals to select one or more ethnic or racial designations and include an "other" designation with the ability to write in other identities; (4) provide the option for individuals to refuse to identify with any of the ethnic or racial designations; (5) collect primary language data with language codes set by the International Organization for Standardization; and (6) ensure that any data concerning an individual's ethnic origin, ethnicity or race that is reported to any other state agency, board or commission is not tabulated or reported without (A) the number or percentage of individuals who identify with each designation as their sole designation, (B) the number or percentage of individuals who identify which each designation either as their sole designation or in combination with others, (C) the number or percentage of individuals who identify with multiple designations and (D) the number or percentage of individuals who do not or refuse to identify with any designations.

This Section requires health care providers with electronic health record systems that can connect to and participate in the State-Wide Health Exchange to collect self-reported patient demographic data and include it in the record systems. This data must include, but is not limited to, race, ethnicity, primary language, insurance status and disability status. This data must comply with the requirements provided in the paragraph above.

By August 1, 2021, OHS must consult with consumer advocates, health equity experts, state agencies and health care providers to create an implementation plan for the changes required by

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this Section. OHS must review demographic changes in race and ethnicity from the U.S. Census Bureau and health data collected by the State and to occasionally reevaluate the standard race and ethnicity categories in consultation with health care providers, consumers and the Joint Committee on Public Health.

§ 19

This Section requires DMHAS to develop a mental health toolkit to assist employers in the State with addressing employee mental health needs arising from COVID-19. The toolkit must identify common mental health issues among employees because of COVID-19, identify the symptoms of such issues and provide information and other resources regarding ways employers can help employees address such issues. DMHAS is required to post this toolkit on its website no later than October 1, 2021.

F. HOUSING

20. PUBLIC ACT 21-34. AN ACT CONCERNING THE RIGHT TO COUNSEL IN EVICTION PROCEEDINGS, THE VALIDITY OF INLAND WETLANDS PERMITS IN RELATION TO CERTAIN OTHER LAND USE APPROVALS AND EXTENDING THE TIME OF EXPIRATION OF CERTAIN LAND USE PERMITS.

§ 1
Effective July 1, 2021

This Section establishes a "right to counsel program" to provide legal representation at no cost to certain income eligible tenants in eviction proceedings.

"Income-eligible" is defined as either (1) having a household at or below 80% of the state median income adjusted for family size as determined by the U.S. Department of Housing and Urban development at the time of the request for representation or (2) receiving public assistance under any of the following programs: Temporary Assistance for Needy Families, Supplemental Nutrition Assistance Program Benefits, Medicaid, Supplemental Security Income, refugee resettlement benefits, rental assistance or the federal Housing Choice Voucher Program. These individuals may receive assistance under the right to counsel program for certain "covered matters" initiated on or after July 1, 2021. "Covered matters" include a notice to quit, a summons and complaint for a summary process action, a lease termination notice for a public or subsidized housing unit or a notice to terminate a state or federal housing subsidy.

The Judicial Branch must use available funds to contract with an administering entity to administer the right to counsel program. The administering entity will use available funding to provide legal representation by "designated organizations." A "designated organization" is defined as any not-

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for-profit legal services organization that provides legal representation in a covered matter to a covered individual. The designated organizations may subcontract with non-profits or community organizations to provide the legal representation and tenant outreach and education.

The Judicial Branch, in consultation with the administering entity, working group and designated organizations is required to approve a single-page plain-language notice to tenants to inform them of their right to counsel under this program. The notice, which at a minimum, must include a phone number for accessing information and applying for assistance, must be publicly posted on the Judicial Branch's website by October 1, 2021. In addition, starting October 1, 2021, any owner, lessor, landlord, housing authority, housing subsidy program administrator or any agent of an owner, lessor or landlord must attach a copy of the approved notice to (1) a notice to quit delivered to a covered individual, (2) a summons and complaint for summary process, (3) a lease termination for public or subsidized housing unit and (4) a notice to terminate a state or federal housing subsidy.

All court notices scheduling mediations or hearings that are sent to self-represented parties in covered matters must also include the plain language information regarding the availability of free legal representation through the right to counsel program.

G. PRIVACY AND CYBERSECURITY

21. PUBLIC ACT 21-59. AN ACT CONCERNING DATA PRIVACY BREACHES. *Effective October 1, 2021*

This Act expands existing law concerning data privacy breaches and includes additional requirements for data breach notice and reporting.

The Act broadens the definition of "personal information" to now include, in addition to an individual's social security number, driver's license or state identification number, credit or debit card number and financial account number (in combination with a required security code or password to gain access to the account), any of the following in combination with an individual's first name or first initial and last name: (i) taxpayer identification number; (ii) identity protection personal identification number from the IRS; (iii) passport number; (iv) military identification number or other identification number issued by the government that is commonly used to verify identity; (v) medical information regarding an individual's medical history, mental or physical condition or medical treatment or diagnosis by a health care professional; (vi) health insurance policy number or subscriber identification number or any unique identifier used by a health insurer to identify the individual; (vii) biometric information consisting of data generated by electronic measurements of an individual's unique physical characteristics used to authenticate or ascertain the individuals identity such as fingerprint, voice print or retinal or iris image; or (viii) any

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username or email address in combination with a password or security question and answer that permits access to an online account.

This Act modifies existing law by removing the requirement that a person "conduct business in the state" for the sections of the Act to apply. The Act broadens the language to now apply to "any person who owns, licenses or maintains computerized data that includes personal information" as it relates to breaches of information of residents of this State.

This Act amends existing law to reduce the permissible time frame for notice to individuals whose personal information was breached or is reasonably believed to have been breached, from ninety (90) days to sixty (60) days after the discovery of the breach, unless a shorter time is required by federal law. If a person identifies other individuals whose personal information may have been breached after the initial sixty (60) days from discovery of the breach, the person is required to notify, in good faith, the additional individuals as expediently as possible. Note that the previous law exempted notification so long as an investigation and consultation with relevant federal, local and state law enforcement agencies determined the breach would not result in harm. The Act now eliminates such consultation requirement and maintains that notification is not required if an appropriate investigation reasonably determines that the breach will not likely result in harm to individuals whose personal information was acquired or accessed.

In addition, in the event of a breach of login credentials, a person may provide notice of breach through an electronic form that directs the individual to change the login credentials, or to take steps to protect the accounts protected by the breached credentials. The Act requires, however, that in the event of a breach to email account information, a person may not provide notification through the email account that was breached if they cannot reasonably verify the affected residents' receipt of such notification. In those instances, the person must provide notice through another permissible method (i.e., written notice, telephone notice, or some other method such as a posting on the person's website or notification via state-wide media if the previous two are not possible) or through clear and conspicuous online notification.

Any person subject to privacy and security standards of HIPAA and the Health Information Technology for Economic and Clinical Health Act ("HITECH") is deemed compliant with this Section so long as any person required to provide notification to residents of this State pursuant to HITECH also provides notice to the Attorney General not later than the time when the notice is provided to residents if notification to the Attorney General would otherwise be required under the Act and the person otherwise complies with all other applicable requirements of this Act. Based on this provision, HIPAA covered entities are not obligated to report to the Attorney General every time they provide breach notices pursuant to HIPAA, since HIPAA covers a broader set of protected information, including paper files as well as computerize data; they only need to report to the Attorney General if they would otherwise be required to report under the Act, which addresses security breaches of specified computerized data containing personal information.

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Furthermore, all documents, materials and information provided in response to an investigative demand in connection with the investigation of a breach of security are exempt from public disclosure as long as the Attorney General makes them available to third parties in furtherance of any such investigation.

22. PUBLIC ACT 21-119. AN ACT INCENTIVIZING THE ADOPTION OF CYBERSECURITY STANDARDS FOR BUSINESSES.
Effective October 1, 2021

This Act creates a safe harbor for covered entities (i.e., any business that handles an individual's personal or restricted information) to avoid punitive damages in tort actions when sued for a data breach of personal or restricted information based on allegations of a failure to implement reasonable cybersecurity controls. The Act includes definitions for each of "personal information," "restricted information" and "data breach" and therefore the safe harbor appears to apply only to the extent the tort action implicates those definitions.

Under the Act, "personal information" mirrors the definition of "personal information" under Connecticut's data breach notification law, which was revised by Public Act No. 21-59. Under both the Act and Public Act 21-59, "personal information" means an individual's first name or first initial and last name in combination with any one or more, of the following data: (i) social security number; (ii) driver's license or state identification number; (iii) credit or debit card number; (iv) financial account number (in combination with a required security code or password to gain access to the account); (v) taxpayer identification number; (vi) identity protection personal identification number from the Internal Revenue Service; (vii) passport number; (viii) military identification number or other identification number issued by the government that is commonly used to verify identity; (ix) medical information regarding an individual's medical history, mental or physical condition or medical treatment or diagnosis by a health care professional; (x) health insurance policy number, subscriber identification number or any unique identifier used by a health insurer to identify the individual; (xi) biometric information consisting of data generated by electronic measurements of an individual's unique physical characteristics used to authenticate or ascertain the individuals identity such as fingerprint, voice print or retinal or iris image; or (xii) any username or email address in combination with a password or security question and answer that permits access to an online account.

"Restricted information" means any information other than an individual's personal information or publicly available information that can be used to identify the individual and likely cause a material risk of identity theft. And, for purposes of this Act, "data breach" means unauthorized access to and acquisition of computerized data that compromises the security or confidentiality of personal information or restricted information as owned or licensed to a covered entity and that causes, reasonably is believed to have caused or reasonably believed will cause a material risk of

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identity theft or other fraud to a person or property. A data breach does not include personal or restricted information that was acquired in good faith by an entity's employee or agent that was not used for an unlawful purpose or personal or restricted information acquired due to a legal or regulatory order.

The safe harbor applies if the covered entity maintained and complied with a written cybersecurity program that contains proper safeguards to protect personal or restricted information and conforms to at least one of the industry recognized cybersecurity frameworks described in the Act. The Act further requires covered entities to conform to any updates or revisions to the identified frameworks within six (6) months of the published updates. The cybersecurity program must also conform to other specified guidelines.

The safe harbor does not apply if a covered entity's failure to implement proper cybersecurity controls was the result of gross negligence or willful or wanton conduct. The Act also does not limit the authority of the Attorney General or the Commissioner of Consumer Protection to seek administrative, legal or equitable relief as otherwise allowed by the general statutes or common law.

H. LONG TERM CARE INSURANCE

23. PUBLIC ACT 21-150. AN ACT CONCERNING LONG-TERM CARE INSURANCE.
Effective January 1, 2022

This Act amends laws governing long-term care insurance to establish a set of affordable benefit options that long-term care insurers must offer in certain circumstances. The Commissioner of DOI must establish the minimum set of affordable benefit options for long-term care insurance to be offered by insurance companies, fraternal benefit societies, hospital service corporations, medical service corporations and health care centers (collectively, "insurance companies") that file a rate filing and plan to implement a premium rate increase for long-term care policies in an amount of 20% or more. The DOI Commissioner must send the insurance companies a notice disclosing the minimum set of affordable benefit options and, if necessary, may adopt regulations to carry out such purposes.

The Act further amends existing law to prohibit insurance companies from delivering, issuing, renewing, continuing or amending any long-term care insurance policies on or after January 1, 2022, unless the entity has been authorized or licensed to sell long-term care insurance and at least one other line of insurance in this State.

In addition, the Act clarifies that not only will insurance companies filing for an increase in premium rates for long-term care insurance policies in an amount exceeding twenty percent have to spread such increase over a period of no less than three (3) years, they will also be prohibited,

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during such chosen period, from filing a rate filing for a premium rate increase for the long-term care insurance policy. Finally, the Act amends current law setting out the three (3) requirements that insurance companies must meet before implementing a premium rate increase. First, the insurance companies must notify policyholders of the increase and now make available to them either the choice to reduce policy benefits for a reduction in the premium rate or the choice to elect coverage that would reflect the minimum set of affordable benefit options; the notice must include a description of the benefit reduction and the prescribed minimum set of affordable benefit options. Second, they must provide policyholders with at least thirty (30) calendar days to either elect a reduction in benefits or a reduction in coverage that reflects the minimum set of affordable benefit options. Lastly, they must state in the notice that a failure to elect a reduction in benefits or coverage reflecting the minimum set of affordable benefit options by the end of the notice period and a failure to cancel the policy will be deemed an election by the policyholder to retain their existing policy benefits.

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