Agency Legislative Proposal - 2022 Session

Document Name: 10.8.21 - DPH - Change of Ownership in Healthcare Facilities Revised November 19, 2021

(If submitting electronically, please label with date, agency, and title of proposal – 092621_SDE_TechRevisions)

State Agency: Department of Public Health
Liaison: Brie Wolf/Jill Kennedy **Phone:** 860-509-7246/860-509-7280 **E-mail:** brie.wolf@ct.gov/jill.kennedy@ct.gov
Lead agency division requesting this proposal: Facility Licensing and Investigations Section
Agency Analyst/Drafter of Proposal: Jill Kennedy

Title of Proposal: An Act Concerning Change of Ownership in Healthcare Facilities
Statutory Reference: Section 1. 19a-493. Initial license and renewal. Prior approval for change in ownership. Multicare institution. Regulations.
Proposal Summary: This proposal removes the requirement for an individual to have more than 10% ownership in a facility for a change of ownership to take place. Additionally, the proposal removes the special requirements that allow for an individual to transfer less than 10% ownership to a blood relative without going through the change of ownership process Section 1 also requires additional information to be included in an application for a change of ownership: 1) disclosing 100% of the ownership, 2) a copy of the sales agreement, 3) disclosure of any other facilities owned by the entity for the past five years, 4) a statement that any other facilities owned by the entity are not the subject of any corrective actions.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

If over ten percent ownership of a health care facility is transferred then the CHOW must be approved by DPH after an inspection of the facility is conducted. Currently, a change in ownership resulting in a transfer to a person related by blood or marriage is *not subject to Department approval* unless (A) Ownership of ten percent or more of the stock is transferred; (B) ownership is transferred in more than one facility or institution; or (C) the facility or institution is the subject of a pending complaint, investigation or licensure action. DPH has seen situations where nursing home owners slowly transfer less than ten percent of ownership to family members, for example.

Both the Departments of Social Services and Public Health have seen a trend in change of ownership applications, that allow for current nursing home owners who have quality of care violations and staffing concerns continue to purchase other nursing homes. This includes nursing home owners from other states that have had their ownership taken away due to patient care concerns. The intent of this proposal is to have disclosure of any financial dealings with companies/services that have an interest in the nursing home, disclosure of any actions taken against their ownership/interest in another facility, or partnerships with family members or other entities. This will allow the Department to review the information and approve or deny the change of ownership.

◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Department of Social Services
Agency Contact (*name, title, phone*): Alvin Wilson and David Seifel
Date Contacted:

Approve of Proposal ☒ **YES** ☐ **NO** ☐ **Talks Ongoing**

Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)* None
State None
Federal None
Additional notes on fiscal impact

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

◊ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs. New Jersey introduced similar laws that the Department reviewed and mirrored some of their requirements. https://www.njleg.state.nj.us/2020/Bills/S3000/2789_I1.HTM

Insert fully drafted bill here

Section 1. Subsection (b) of section 19a-493 of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(b) (1) A nursing home license may be renewed biennially after (A) an unscheduled inspection conducted by the department, (B) submission of the information required by section 19a-491a, and (C) submission of evidence satisfactory to the department that the nursing home is in compliance with the

provisions of this chapter, the [Public Health Code] regulations of Connecticut state agencies and licensing regulations.

(2) Any change in the ownership of a facility or institution, as defined in section 19a-490, owned by an individual, partnership or association or the change in ownership or beneficial ownership of [ten per cent or more of] the [stock of a corporation] entity which owns, conducts, operates or maintains such facility or institution, including change in ownership or beneficial ownership resulting in a transfer to a person related by blood or marriage to such an owner or beneficial owner, shall be subject to prior approval of the department. Such application shall include, but not be limited to disclosure of the following: (A) If the facility or institution is the subject of a pending complaint, investigation or licensure action or (B) the facility has been subject to (i) three or more civil penalties imposed through final order of the commissioner in accordance with the provisions of sections 19a-524 to 19a-528, inclusive, or civil penalties imposed pursuant to the statutes or regulations of another state, during the two-year period preceding the application, (ii) in any state, sanctions, other than civil penalties of less than twenty thousand dollars, imposed through final adjudication under the Medicare or Medicaid program pursuant to Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as from time to time amended, or (iii) in any state, such potential owner's Medicare or Medicaid provider agreement terminated or not renewed. Upon receiving such application, the Department shall schedule an [after a scheduled] inspection of such facility or institution [is conducted by the department, provided such approval shall be conditioned upon a showing by such] to determine if the facility or institution to the commissioner that it has complied with all requirements of this chapter, and the regulations of Connecticut state agencies relating to licensure of their facility type [and all applicable requirements of the Public Health Code]. If the facility or institution is not in compliance with the requirements of a corrective action plan or in violation of the statutes or regulations of Connecticut State Agencies, the commissioner may deny the change of ownership or require the new owner to sign a consent order which shall include, but not be limited to, the implementation of a plan of corrections for violations of any statutes and regulations of Connecticut state agencies, which shall be corrected within a specified period of time. The commissioner may assess a civil penalty of not more than one thousand dollars for each day the owner is in violation of the statutes and regulations of Connecticut state agencies or such consent order. Notice of any such proposed change of ownership shall be given to the department at least one hundred twenty days prior to the effective date of such proposed change. Should the Commissioner deny an application for a change of ownership, a person related by blood or marriage to the applicant shall not apply to acquire ownership interest in the facility or institution. [Any such change in ownership or beneficial ownership resulting in a transfer to a person related by blood or marriage to such an owner or beneficial owner shall not be subject to prior approval of the department unless: (A) Ownership or beneficial ownership of ten per cent or more of the stock of a corporation, partnership or association which owns, conducts, operates or maintains more than one facility or institution is transferred; (B) ownership or beneficial ownership is transferred in more than one facility or institution; or (C) the facility or institution is the subject of a pending complaint, investigation or licensure action If the facility or institution is not in compliance, the commissioner may require the new owner to sign a consent order providing reasonable assurances that the violations shall be corrected

within a specified period of time. Notice of any such proposed change of ownership shall be given to the department at least one hundred twenty days prior to the effective date of such proposed change.] For the purposes of this subdivision, "a person related by blood or marriage" means a parent, spouse, child, brother, sister, aunt, uncle, niece or nephew.

(3) For the purposes of this [subdivision] subsection, a change in the legal form of the ownership entity, including, but not limited to, changes from a corporation to a limited liability company, a partnership to a limited liability partnership, a sole proprietorship to a corporation and similar changes, shall not be considered a change of ownership if the beneficial ownership remains unchanged and the owner provides such information regarding the change to the department as may be required by the department in order to properly identify the current status of ownership and beneficial ownership of the facility or institution. For the purposes of this subdivision, a public offering of the stock of any corporation that owns, conducts, operates or maintains any such facility or institution shall not be considered a change in ownership or beneficial ownership of such facility or institution if the licensee and the officers and directors of such corporation remain unchanged, such public offering cannot result in an individual or entity owning ten per cent or more of the stock of such corporation, and the owner provides such information to the department as may be required by the department in order to properly identify the current status of ownership and beneficial ownership of the facility or institution.

(4) Prior to transferring ownership, the prospective new owner of such facility shall submit an application, in a form and manner as prescribed by the commissioner, to the department for approval of the change in ownership pursuant to subdivision (2) of this subsection. The application shall include, but not be limited to the following: (A) A cover letter stating the applicant's intent to purchase the facility or institution and identification of the facility by name, address, county, and number and type of licensed beds; (B) a description of the proposed transaction, including the current owners of the facility or institution; (C) identification of one hundred percent of the proposed new owners and owners of any parent corporation that is not publicly traded; (D) if applicable, a copy of an organizational chart, including parent corporations and wholly-owned subsidiaries; (E) a copy of the agreement of sale and, if applicable, a copy of any lease and management agreements, (F) a projection of profits and losses for the next three years and a capital budget projection for the next three years, including, but not limited to, accounts payable with amount due, days overdue and details of payment to all such accounts; and (G) disclosure of any licensed health care facilities owned, operated, or managed by the proposed owners and principals in any state or territory of the United States or in the District of Columbia in the preceding five years, along with audited financial statements for each such facility for the last three years during which the facility was owned, operated, or managed by the third party entity; (H) disclosure of any direct or indirect interests, including such interests in intermediate entities, parent, management, and property companies, and other related-party entities; and (I) a statement that the facility or institution is not the subject of a pending complaint, investigation or licensure action in Connecticut or reciprocal action from another state.


STATE OF CONNECTICUT
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Agency Legislative Proposal - 2022 Session

Document Name: 10.6.21 - DPH - Residential Care Home Definition and Discharge Statute Revised November 19, 2021

State Agency: Department of Public Health
Liaison: Brie Wolf / Jill Kennedy **Phone:** (860) 509-7246/ (860) 509-7280 **E-mail:** brie.wolf@ct.gov / jill.kennedy@ct.gov
Lead agency division requesting this proposal: Facility Licensing and Investigations Section and Legal Office
Agency Analyst/Drafter of Proposal: Jill Kennedy, Joanne Yandow, Olinda Morales

Title of Proposal: An Act Concerning Revisions to the Statutes Pertaining to Discharges in a Residential Care Home
Statutory Reference: Sec. 19a-535a. Residential care home. Transfer or discharge of patients. Appeal. Hearing.
Proposal Summary: This proposal revises the discharge process for residential care homes (RCH) to align with the discharge process with the state's landlord/tenant law, which qualify a RCH as a home and community based setting (HCBS) and allow for residents to continue to receive services under Medicaid waivers.

PROPOSAL BACKGROUND

◊ Reason for Proposal

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?

(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year?

(3) Have certain constituencies called for this action?

(4) What would happen if this was not enacted in law this session?

Section 19a-535a, as currently written, allows an RCH resident to request an appeal hearing from DPH when they do not agree with their transfer or discharge from a residential care home. DPH's hearing office hears these appeals and determines whether the discharge fell within the parameters outlined in the statute. That decision is final, and the resident cannot contest it.

The proposal provides more protections and appeal rights through the Superior Court during the discharge process, as comparable to current landlord/tenant protections. Pursuant to 42 CFR

441.301, residents must have comparable protections to those provided to tenants under the state's landlord/tenant law to qualify as a home and community based setting.

States must document compliance with the 42 CFR 441.301 no later than March 17, 2023 to meet the home and community based setting standard. It is imperative that this bill move forward during the 2022 legislative session.

When residential care home qualifies as a home and community based setting, RCH residents who are currently waiver participants can continue to participate in the waiver and receive waiver services. Approximately, 250 individuals currently reside in residential care homes and receive services under Medicaid waivers.

Services, such as personal care services and medical administration, and room and board are entirely state funded. If residential care homes qualified as home and community based settings, DSS could reimburse the personal care services, medical administration and other home care services under the waiver and claim the federal match on these services.

DSS and DPH have been meeting for over three years discussing ways to ensure that the RCHs will be able to comply with the HCBS rules in 42 CFR §441.301. DSS fully supports this proposal and believes that is necessary to provide services for individuals residing in RCHs under Medicaid Waivers. DPH, DSS and Aging Disability Services (ADS) agree that this language is the best possible compromise for all parties involved in the discharge process.

◊ **Origin of Proposal** ☐ **New Proposal** ☒ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

Over the past three years, the Departments of Social Services and Public Health have been providing guidance to the Connecticut Association of Residential Care Homes by speaking at their association meetings regarding the importance of this statutory revision and the impact it will have on their businesses.

In the 2021 regular session, this language was introduced as Senate Bill 922, An Act Concerning Revisions To The Statutes Pertaining To Discharges In A Residential Care Home. It received a public hearing, passed the Public Health Committee, but was not taken up by the Senate Chamber.

The language in the proposal was also in Section 12 of House Bill 5020, the Governor's Budget Implementer governing public health during the 2020 session. Because of the onset of the

COVID-19 pandemic, the 2020 regular legislative session ended, and this proposal did not move forward.

In 2015, the Department introduced House Bill 6887, An Act Concerning The Department of Public Health's Recommendations Regarding the Protection of Residents in Healthcare Institutions. This bill included minor revisions to Section 19a-535a of the general statutes and was opposed by the industry. The bill died in committee after the public hearing process.

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Department of Social Services
Agency Contact (*name, title, phone*): Alvin Wilson and David Seifel
Date Contacted: Click here to enter text.

Approve of Proposal ☒ **YES** ☐ **NO** ☐ **Talks Ongoing**

Summary of Affected Agency's Comments
DSS and DPH have been meeting for over three years to discuss ways to ensure that the RCHs will be able to comply with the HCBS rules in 42 CFR §441.301**.** DSS fully supports this proposal and believes that is necessary to provide services for individuals residing in RCHs under Medicaid Waivers.

Will there need to be further negotiation? ☐ **YES** ☒**NO**

Agency Name: Department of Aging and Disability Services
Agency Contact (*name, title, phone*): Andrew Norton
Date Contacted: Click here to enter text.

Approve of Proposal ☒ **YES** ☐ **NO** ☐ **Talks Ongoing**

Summary of Affected Agency's Comments
The Long Term Care Ombudsman Program fully supports this proposal and believes that is necessary to provide services for individuals residing in RCHs under Medicaid Waivers.

Will there need to be further negotiation? ☐ **YES** ☒**NO**

Agency Name: Attorney General's Office
Agency Contact (*name, title, phone*): Cara Passaro
Date Contacted: Click here to enter text.

Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**

Summary of Affected Agency's Comments
Will there need to be further negotiation? ☐ **YES** ☐**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)* None
State This proposal will allow a RCH to qualify as home and community based settings, which allow RCH residents who are also waiver participants to continue to receive much needed waiver services. There should be no fiscal impact to the state as the individuals receiving waiver services will continue to receive services they are already receiving. The state is already reimbursing waiver providers for these services.
Federal RCHs will be considered HCBS and RCH residents participating in waivers can continue to participate and receiver Medicaid waiver services.
Additional notes on fiscal impact

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

DPH's Legal Office will likely see an increase in the number of appeals filed by RCH residents upon discharge. The Attorney General's Office will defend the Department's position on appeals, as an aggrieved party will now have the right to appeal the DPH final decision to the Superior Court.

◊ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs. This proposal will allow a Residential Care Home (RCH) to qualify as a HCBS under federal law and RCH residents will continue to receive Medicaid waiver services under the Home and Community Based Waiver programs.

Insert fully drafted bill here

Section 19a-535a of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2020):

(a) As used in this section: [, a "facility"]

(1) "Facility" means a residential care home, as defined in section 19a-490; [.]

(2) "Emergency" means a situation in which a resident of a facility presents an imminent danger to his or her own health or safety, the health or safety of another resident or the health or safety of an employee or the owner of the facility;

(3) "Department" means the Department of Public Health; and

(4) "Commissioner" means the Commissioner of Public Health, or the commissioner's designee.

(b) A facility shall not transfer or discharge a resident from the facility unless (1) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility, (2) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility, (3) the health or safety of individuals in the facility is endangered, (4) the resident has failed, after reasonable and appropriate notice, to pay for a stay or a requested service[,] at the facility or (5) the facility ceases to operate. In the case of an involuntary transfer or discharge the facility shall provide written notice to the resident and, if known, his or her legally liable relative, guardian or conservator [shall be given a thirty-day written notification which] at least thirty days prior to the proposed transfer or discharge date, except when the facility has requested an immediate transfer or discharge in accordance with subsection (e) of this section, and the notice shall include[s] the reason for the transfer or discharge, the date on which the transfer or discharge shall be effective and notice of the right of the resident to appeal a transfer or discharge by the facility pursuant to subsection (d) of this section, and the resident's right to represent himself or herself or be represented by legal counsel. Such notice shall be in a form and manner prescribed by the commissioner, as modified from time to time, and shall include the name, mailing address and telephone number of the State Long-Term Care Ombudsman and be sent by facsimile or electronic communication to the Office of the Long-Term Care Ombudsman on the same day as the notice is given to the resident. If the facility knows the resident has, or the facility alleges that the resident has, a mental illness or an intellectual disability, the notice shall also include the name, mailing address and telephone number of the entity designated by the Governor in accordance with section 46a-10b to serve as the Connecticut protection and advocacy system. No resident shall be involuntarily transferred or discharged from a facility if such transfer or discharge presents imminent danger of death to the resident.

(c) The facility shall be responsible for assisting the resident in finding [appropriate placement] an alternative residence. A discharge plan, prepared by the facility, in a form and manner prescribed by the commissioner, as modified from time to time, [which indicates] shall include the resident's individual needs and shall [accompany the patient] be submitted to the resident not later than seven days after the notice of discharge is issued to the resident. The facility shall submit the discharge plan to the commissioner at or before the hearing held pursuant to subsection (d) of this section.

(d) (1) [For transfers or discharges effected on or after October 1, 1989, a] A resident or his or her legally liable relative, guardian or conservator who has been notified by a facility, pursuant to subsection (b) of this section, that he or she will be transferred or discharged from the facility may appeal such transfer or discharge to the Commissioner of Public Health by filing a request for a hearing with the commissioner [within ten] not later than ten days [of] after the receipt of such notice. Upon receipt of any such request, the commissioner [or his designee] shall hold a hearing to determine whether the transfer or discharge is being effected in accordance with this section. Such a hearing shall be held [within seven] not later than seven business days [of] after the receipt of such request. [and a determination made by the] The commissioner [or his designee] shall issue a decision not later than [within] twenty days [of the termination] after the closing of the hearing record. The hearing shall be conducted in accordance with chapter 54.

[(2) In an emergency the facility may request that the commissioner make a determination as to the need for an immediate transfer or discharge of a resident. Before making such a determination, the commissioner shall notify the resident and, if known, his legally liable relative, guardian or conservator. The commissioner shall issue such a determination no later than seven days after receipt of the request for such determination. If, as a result of such a request, the commissioner or his designee determines that a failure to effect an immediate transfer or discharge would endanger the health, safety or welfare of the resident or other residents, the commissioner or his designee shall order the immediate transfer or discharge of the resident from the facility. A hearing shall be held in accordance with the requirements of subdivision (1) of this subsection within seven business days of the issuance of any determination issued pursuant to this subdivision.

(3) Any involuntary transfer or discharge shall be stayed pending a determination by the commissioner or his designee. Notwithstanding any provision of the general statutes, the determination of the commissioner or his designee after a hearing shall be final and binding upon all parties and not subject to any further appeal.]

(2) Any involuntary transfer or discharge that is appealed under this subsection shall be stayed pending a final determination by the commissioner.

(3) The commissioner shall send a copy of his or her decision regarding a transfer or discharge to the facility, the resident and the resident's legal guardian, conservator or other authorized representative, if known, or the resident's legally liable relative or other responsible party, and the State Long-Term

Care Ombudsman.

(e) (1) In the case of an emergency, the facility may request that the commissioner make a determination as to the need for an immediate transfer or discharge of a resident by submitting a sworn affidavit attesting to the basis for the emergency transfer or discharge. The facility shall provide a copy of the request for an immediate transfer or discharge to the resident and the notice described in subsection (b) of this section. After receipt of such request, the commissioner may issue an order for the immediate temporary transfer or discharge of the resident from the facility. The temporary order shall remain in place until a final decision is issued by the commissioner, unless earlier rescinded. The commissioner shall issue the determination as to the need for an immediate transfer or discharge of a resident no later than seven days after receipt of the request from the facility. A hearing shall be held not later than seven business days after the determination issued pursuant to this section. The commissioner shall issue a decision not later than twenty days after the closing of the hearing record. The hearing shall be conducted in accordance with the provisions of chapter 54.

(2) The commissioner shall send a copy of his or her decision regarding an emergency transfer or discharge to the facility, the resident and the resident's legal guardian, conservator or other authorized representative, if known, or the resident's legally liable relative or other responsible party and the State Long-Term Care Ombudsman.

(3) If the commissioner determines, based upon the request, that an emergency does not exist, the commissioner shall proceed with a hearing in accordance with the provisions of subsection (d) of this section.

(f) A facility or resident who is aggrieved by a final decision of the commissioner may appeal to the Superior Court in accordance with the provisions of chapter 54. Pursuant to subsection (f) of section 4-183, the filing of an appeal to Superior Court shall not, of itself, stay enforcement of an agency decision. The Superior Court shall consider an appeal from a decision of the Commissioner of Public Health pursuant to this section as a privileged case in order to dispose of the case with the least possible delay.

Agency Legislative Proposal - 2022 Session

Document Name: 10.22.21 DPH Youth Risk Behavior Survey Revised November 19, 2021

State Agency: Department of Public Health
Liaison: Brie Wolf / Jill Kennedy **Phone:** (860) 509-7246/ (860) 509-7280 **E-mail:** brie.wolf@ct.gov / jill.kennedy@ct.gov
Lead agency division requesting this proposal: Health Statistics and Surveillance
Agency Analyst/Drafter of Proposal: Celeste Jorge and Lisa Kessler

Title of Proposal: An Act Concerning the Centers for Disease Control and Prevention Youth Risk Behavior Survey
Statutory Reference: NEW
Proposal Summary: Require DPH to biennially administer the Youth Risk Behavior Survey (YRBS), also known as the Connecticut School Health Survey (CSHS), to students in grades nine through twelve, and require selected schools to participate in the survey.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

1. *Have there been changes in federal/state/local laws and regulations that make this legislation necessary?*
2. *Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year?*
3. *Have certain constituencies called for this action?* Yes , the Office of the Child Advocate
4. *What would happen if this was not enacted in law this session?*

The Youth Risk Behavior Survey (YRSB) is developed by the Centers for Disease Control and Prevention (CDC) and health experts in their respective fields, with national health objectives in mind.

The primary purpose of the Youth Risk Behavior Survey is to monitor priority health risk behaviors that contribute to the leading causes of morbidity, mortality, and social problems among youth and young adults in the United States. These behaviors fall into several categories: injuries and violence, tobacco use, alcohol and other drug use, sexual behaviors, mental health, unhealthy dietary behaviors, physical inactivity, academic and school climate factors, and family connectedness.

DPH develops additional questions to be included in the survey that are relevant to the health concerns of the state's high school students in consultation with the Departments of Education,

Children and Families, and Mental Health and Addiction Services; the Office of Early Childhood; and any other agency or public interest group DPH deems necessary.

High schools are randomly chosen by the CDC to participate in the survey, but often decline to participate. Under this proposal a selected school will be required to administer the survey. **This would begin in the 2022-2023 school year.**

The YRBS provides indispensable data, but only if schools actually administer the survey. With the current option to decline survey participation – which many schools do – the survey is an ineffective means of gathering the data. Requiring the selected schools to participate will provide this much needed information.

Sections 65 and 146 of Public Act 21-1 of the June Special Session, An Act Concerning Responsible And Equitable Regulation Of Adult-Use Cannabis, highlight the need for this essential survey data. The Act establishes a program to collect timely public health information on cannabis associated illnesses and adverse events, including data on cannabis use among youths, and to share cannabis use associated morbidity and mortality statistics in order to inform policy makers and citizens on the impact of cannabis legalization.

The Act also requires DPH and other state agencies to make recommendations regarding the impacts of cannabis legalization. Requiring the selected schools to participate in the YRBS will provide this much needed information and help implement the requirements of the cannabis law.

◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

Although DPH has not introduced this proposal in sessions past, similar language was in House Bill 6399, An Act Concerning The Centers For Disease Control And Prevention Youth Risk Behavior Survey, and Senate Bill 888, An Act Responsibly And Equitably Regulating Adult-Use Cannabis, from the 2021 regular session. Neither bill passed both chambers – House Bill 6399 was not taken up on the Senate Floor and Senate Bill 888 was not taken up on the House Floor.

Additionally, House Bill 5333, An Act Concerning The Centers For Disease Control And Prevention Youth Risk Behavior Survey, was introduced in the 2020 regular session, which was cut short due to the onset of the COVID-19 pandemic.

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: State Department of Education **Agency Contact (*name, title, phone*):** Laura Stefon **Date Contacted:** Approve of Proposal ☐ **YES** ☐ **NO** ☒ **Talks Ongoing**
Summary of Affected Agency's Comments
Will there need to be further negotiation? ☐ **YES** ☒**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)* None
State None
Federal The survey has been consistently funded by CDC for many years. Administration of the survey is contingent upon receipt of funding from CDC.
Additional notes on fiscal impact The survey administration is funded by a CDC Cooperative Agreement and schools do not incur any costs to administer the survey and are provided a monetary stipend.

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

Programs that rely on YRBS data include the Connecticut Suicide Advisory Board, which is a multi-agency collaboration on prevention of suicide, and also include a multi-agency collaboration on preventing adverse childhood experiences. Data from the YRBS is reported and tracked in the state's health assessment, Healthy Connecticut 2025, as well as the General Assembly, Committee on Children, Results Based Accountability (RBA) Child Report Card. Data from the YRBS also informs the State Department of Education's initiatives on school climate and safety, school absenteeism, and comprehensive school health. At DPH, the YRBS data informs the programs funded by the Maternal and Child Health Block Grant, Preventive Health and Health Services Block Grant, and many chronic and infectious disease programs.

◊ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs.

The impact of the YRBS can be tracked over time by monitoring student response rates, to assure that the response is high enough to report the data by demographic characteristics. The data is currently available and does not have to be developed. The success of the survey will be assured by requiring school participation.

Other measures of evaluation include the tracking of agencies, organizations and programs that use or request the data, as well as the number of statistical or programmatic impact documents that get developed and disseminated (fact sheets, issue briefs). Data will inform prevention programs in school and community settings to target and improve mental health and student success, and decrease risky behaviors that lead to injury, teen pregnancy, tobacco and drug use, and obesity.

The YRBS is mandated in selected schools in several states: Virginia, Maryland, and Washington, DC. Other states are considering implementing a mandate. States with a YRBS mandate are able to consistently provide health statistics for numerous health risk behaviors that are the leading causes of injury, illness and death in youth.

Insert fully drafted bill here

(NEW) (*Effective July 1, 2022*) For the school year commencing July 1, 2022, and biennially thereafter, the Department of Public Health shall administer the Connecticut School Health Survey to students in grades nine to twelve, inclusive, provided the department receives funding from the federal Centers for Disease Control and Prevention for such purpose. The survey shall be based on the Youth Risk Behavior Survey developed by the National Centers for Disease Control and Prevention. Each local or regional board of education shall administer the survey to the high school in their district that is randomly selected by the Centers for Disease Control and Prevention to participate in the survey, in accordance with guidelines provided by the department. Such guidelines shall include, but not be limited to, (1) the survey protocol as required by the Centers for Disease Control and Prevention, (2) the manner by which parents are given the opportunity to exclude their children from the survey, (3) the requirement for the survey to be anonymous and administered in a manner designed to protect student privacy, (4) the timeframe for completion of the survey, and (5) the process by which the results of such survey are to be submitted to the department.

Agency Legislative Proposal - 2022 Session

Document Name: 10.8.21 – DPH – Legionella Mitigation Revised 11-19-2021

(If submitting electronically, please label with date, agency, and title of proposal – 092621_SDE_TechRevisions)

State Agency: Department of Public Health

Liaison: Brie Wolf/Jill Kennedy
Phone: 860-509-7246/860-509-7280
E-mail: brie.wolf@ct.gov/jill.kennedy@ct.gov

Lead agency division requesting this proposal: Environmental Health and Drinking Water Branch, Drinking Water Section

Agency Analyst/Drafter of Proposal: Lori Mathieu, Mike Hage, Lisa Kessler

Title of Proposal: An Act Concerning Legionella Mitigation

Statutory Reference: NEW

Proposal Summary:

Section 1.

Require water companies that serve water to more than 1000 persons and provide water to health care facilities to perform monitoring for total coliform, residual disinfectant, pH, turbidity and temperature at sites in the distribution system that are representative of the water entering such health care facility. Currently, there are 63 facilities that are served by on-site wells and are regulated by DPH as public water systems. The remaining 339 facilities are served by large water systems.

Require water companies that add chemical disinfectant such as chlorine or chloramine, or purchase chlorinated water, to maintain the residual disinfectant concentration at a minimum of 0.10 parts per million (ppm) throughout the water distribution system. There are currently 87 out of 91 large public water systems that currently have chlorinated water.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

According to the Centers for Disease Control and Prevention (CDC), Legionella bacteria are the most commonly reported cause of waterborne outbreaks from drinking water sources. These bacteria cause a disease called legionellosis. One form of the disease, Legionnaire's disease,

presents as a type of pneumonia which can be fatal in highly immunocompromised individuals. The other form, called Pontiac fever, presents like the flu and is typified by a high attack rate. Pontiac fever is largely self-limiting and most patients get better without medical intervention, but it can make an entire workforce or apartment dwellers or other groups ill, all at the same time. Both forms of legionellosis are contracted when susceptible people breathe in aerosolized water (fine mists) that are contaminated with Legionella bacteria.

Connecticut has seen an upward trend in the number of Legionnaires' Disease cases, and a recent review of Connecticut's 2021 death data shows a potential uptick in the number of Legionnaires' Disease related deaths.

Legionellosis is an environmental disease that is completely preventable. Therefore, public health intervention is of primary importance. Environmental control measures focus on minimizing colonization of water distribution systems with Legionella bacteria and minimizing human exposures via inhalation of mists or aerosols contaminated with these bacteria.

There are two parties responsible for providing safe drinking water to residents. The regulated public water system is responsible for delivering safe drinking water to the building. Regulated public water systems are governed by certain regulations from the US EPA and CT DPH. Once safe water is delivered to buildings, the building owner is responsible for ensuring that the water does not become compromised by the internal distribution network and related mechanical equipment. Building owners are governed by state and local building codes, but the building codes only address very specific elements. Many elements inside of buildings with respect to the *maintenance* of that internal network remain unregulated.

Currently, regulated public water systems are required to perform a number of tests on water delivered to buildings as specified by the US Environmental Protection Agency (EPA) and CT Department of Public Health (DPH). These include certain physical and chemical parameters that can help prevent the growth of Legionella bacteria in water distribution systems. This proposal requires that water companies add a representative test site closest to respective health care facilities they serve to ensure that testing data is more relevant for these health care facilities. This data will help Medicare certified healthcare facilities create the water management plans required by CMS for the buildings on their respective campuses.

A recent study published in the American Water Works Association's Water Science periodical in June of 2019, as authored by Mark LeChevallier, and titled "Occurrence of Culturable Legionella Pneumophila in Drinking Water Distribution Systems," shows that the bacterium Legionella can be better controlled in the water distribution system when the residual disinfectant is maintained at or above 0.10 parts per million (ppm) and recommends that water utilities maintain at least 0.1 ppm chlorine residual to prevent the Legionella bacteria from proliferating and impacting the public health of the drinking water consumer.

◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: University of Connecticut Health Center
Agency Contact (*name, title, phone*): Joann Lombardo and Gail Garber
Date Contacted:

Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**

Summary of Affected Agency's Comments
Click here to enter text.

Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Mental Health and Addiction Services
Agency Contact (*name, title, phone*): Mary Kate Mason
Date Contacted:

Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**

Summary of Affected Agency's Comments
Click here to enter text.

Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Children and Families
Agency Contact (*name, title, phone*): Vincent Russo
Date Contacted:

Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**

Commented [WB1]: John Dempsey Hospital and UConn infirmary

Commented [WB2]: Whiting Hospital

Commented [WB3]: Solnit

Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Veterans Affairs **Agency Contact (*name, title, phone*):** Tammy Marzik **Date Contacted:** Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Commented [WB4]: Veterans nursing home in Rocky Hill?

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)* None anticipated.
State Minimal or no fiscal impact.
Federal None anticipated
Additional notes on fiscal impact

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

◊ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs. The CDC Legionnaires' Disease Surveillance Summary Report in 2017 for data collected from 2000 through 2017, noted a total of 63,529 confirmed Legionnaires' disease cases were reported to the National Notifiable Diseases Surveillance System (NNDSS) from 52 U.S.

jurisdictions. The crude national incidence rate increased 5.5-fold from 0.42 per 100,000 persons in 2000 to 2.29 per 100,000 persons in 2017. There were 6,141 confirmed Legionnaires' disease cases (1.90/100,000 persons) reported to NNDSS in 2016 and 7,458 cases (2.29/100,000 persons) reported in 2017. Please see the link to the report at https://www.cdc.gov/legionella/health-depts/surv-reporting/2016-17-surv-report-508.pdf.

Similar to the national trend, Connecticut has also seen an upward trend in the number of Legionnaires' Disease cases, and a recent review of Connecticut's 2021 death data shows a potential uptick in the number of Legionnaires' Disease related deaths.

The Department is aware of several states that require the minimum chlorine residual in the distribution system to be over 0.1 mg/L and has reached out to the States via Association of State Drinking Water Administrators to assess the implication, if any, of a minimum residual on disinfection byproducts.

Insert fully drafted bill here

Section 1. (NEW) (*Effective October 1, 2022*):
Each water company, as defined in Section 25-32a, serving one thousand or more persons that supplies drinking water to a hospital or nursing home, as defined in section 19a-490, shall sample the water system for coliform, residual disinfectant, pH, turbidity, and temperature during each calendar quarter at sites in the distribution system that are representative of the water entering such hospital or nursing home.

Section 2. (NEW) (*Effective October 1, 2022*):
A water company as defined in section 25-32a that adds chlorine or chloramine to its drinking water, or purchases chlorinated water, shall maintain the residual disinfectant concentration at a minimum of 0.1 parts per million throughout the water distribution system.

Agency Legislative Proposal - 2022 Session

Document Name: 10.8.21 – DPH – Private and Semipublic Well Testing Revised 11/22/2021

(If submitting electronically, please label with date, agency, and title of proposal – 092621_SDE_TechRevisions)

State Agency: Department of Public Health
Liaison: Brie Wolf / Jill Kennedy **Phone:** (860) 509-7246/ (860) 509-7280 **E-mail:** brie.wolf@ct.gov / jill.kennedy@ct.gov
Lead agency division requesting this proposal: Environmental Health and Drinking Water Branch, Environmental Health Section
Agency Analyst/Drafter of Proposal: Lori Mathieu, Jim Vannoy, Ryan Tetreault

Title of Proposal: Revisions to Testing Requirements for Private Wells and Semi Public Wells
Statutory Reference: CGS Sec. 19a-37. Regulation of water supply wells and springs. Definitions. Information and requirements re testing of private residential wells or semipublic wells. Transportation of water in bulk by bulk water hauler.
Proposal Summary: This proposal requires 1) newly constructed private wells and semipublic wells and 2) all private wells and semipublic wells part of a real estate transaction to test for total coliform, nitrate, nitrite, sodium chloride, iron, manganese, hardness, turbidity, pH, sulfate, apparent color, odor, arsenic, and uranium.

PROPOSAL BACKGROUND

◊ Reason for Proposal

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?

(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year?

(3) Have certain constituencies called for this action?

(4) What would happen if this was not enacted in law this session?

There are approximately 322,578 private residential wells in Connecticut that serve about 23% of the State's population. Semipublic wells supply non-residential populations at facilities that operate less than 60 days per year or supply less than 25 people per day. Examples of semipublic wells include youth camps, fairgrounds, small condo associations or homeowner associations, and small businesses. There are no current requirements to test an existing well once the testing associated with the well's initial construction has been completed.

Under this proposal, the property owner and DPH will receive water quality data from the private labs conducting the private or semipublic well testing. DPH will analyze these results to

determine trends of water quality over time and determine if any results exceed a water quality action level or maximum contaminant level that warrant follow up by DEEP or local health departments.

This proposal will allow for potential homeowners to be aware of the quality of the water they will be consuming in their new home. Homeowners will be able to educate themselves on potential water quality contaminants and allow for implementation of mitigation strategies to reduce the exposure risks associated with drinking water with elevated levels of contaminants. Mitigation of a water quality contaminant can be achieved through use of bottled water, installation of a treatment system, or connection to a regulated community public water system if one is available and a connection is feasible.

◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

Click here to enter text.

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Department of Energy Environmental Protection
Agency Contact (*name, title, phone*): Harrison Nantz
Date Contacted: Proposal for changes to private well testing requirements presented during 8/3/21 Water Planning Council meeting.

Approve of Proposal ☐ **YES** ☐ **NO** ☒ **Talks Ongoing**

Summary of Affected Agency's Comments
Increased testing of wells may result in an increased finding of areas of the state that require investigation by DEEP to determine if manmade activities caused the private wells or semipublic wells to be impacted.

Will there need to be further negotiation? ☒ **YES** ☐**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)*
As written, the current statutes require local health to receive copies of the water quality test results when an individual chooses to conduct water quality testing as part of the purchase of a house, usually during the home inspection process. The proposed changes to the statutes will

likely result in an increase of results being sent to the local health department where the well associated with the sale of a property is located. The majority of labs send water quality test results associated with a home sale via email to local health departments. We don't believe the increase of test results being submitted to local health departments will create a burden.
State 1 FTE for an Epidemiologist 2 will be needed to develop and maintain a database that will be used to track and analyze water quality test results associated with the sale of a property to be submitted electronically to the Department of Public Health. The FTE will assist to inform local health departments where areas of water quality results are identified at levels that exceed a maximum contaminant level or action level.
Federal None.
Additional notes on fiscal impact

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

DPH will be able to use the well water data to conduct an analysis of the results to determine trends of water quality over time and to determine if any water quality results exceed an action level or maximum contaminant level that would warrant follow up by DEEP or local health departments.

Additionally, the water quality data can be used to determine if outreach and education is needed in certain areas of the state where the data shows elevated levels of a certain contaminant. One specific example of analysis of water quality data received from the sale of property could be to evaluate the levels of sodium and chloride in wells and to establish trends of the levels at different times of the year at various locations across the state.

The water quality data can also be used as a planning tool to identify areas of the state supplied by private wells or semipublic wells that are impacted from elevated levels of contaminants and would be best served by infrastructure investment and improvements, such as the extension of public water mains.

◊ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs.

A study recently completed by the United States Geological Survey (USGS) documented the prevalence of arsenic and uranium found in private wells in Connecticut; therefore, the statutes are being updated to include required testing of these two water quality parameters.
This proposal is consistent with the findings of the Connecticut Water Planning Council 's State Water Plan Implementation Team that private wells should be tested at least minimally to be protective of public health. UConn, DPH, DEEP, local health directors and several others served on that implementation team. Link to the final report: https://portal.ct.gov/-/media/Water/WPC-2021/Private-Well-Water-Quality-Workgroup---Final-recommendations-June-2021.pdf

Insert fully drafted bill here

Sec. 6. Section 19a-37 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(a) As used in this section:

(1) "Laboratory or firm" means an environmental laboratory registered by the Department of Public Health pursuant to section 19a-29a;

(2) "Private well" means a water supply well that meets all of the following criteria: (A) Is not a public well; (B) supplies a residential population of less than twenty-five persons per day; and (C) is owned or controlled through an easement or by the same entity that owns or controls the building or parcel that is served by the water supply well;

(3) "Public well" means a water supply well that supplies a public water system;

(4) "Semipublic well" means a water supply well that (A) does not meet the definition of a private well or public well, and (B) provides water for drinking and other domestic purposes; and

(5) "Water supply well" means an artificial excavation constructed by any method for the purpose of obtaining or providing water for drinking or other domestic, industrial, commercial, agricultural, recreational or irrigation use, or other outdoor water use.

(b) The Commissioner of Public Health may adopt regulations in regulations of Connecticut state agencies for the preservation of the public health pertaining to (1) protection and location of new water

supply wells or springs for residential or nonresidential construction or for public or semipublic use, and (2) inspection for compliance with the provisions of municipal regulations adopted pursuant to section 22a-354p. All private wells and semipublic wells constructed after October 1, 2022, shall be tested for total coliform, nitrate, nitrite, sodium, chloride, iron, manganese, hardness, turbidity, pH, sulfate, apparent color, odor, arsenic, and uranium. Nothing in this section shall prevent a person from testing for additional contaminants.

(c) The Commissioner of Public Health shall adopt regulations, in accordance with chapter 54, for the testing of water quality in private wells and semipublic wells. Any laboratory or firm which conducts a water quality test on a private well [serving a residential property] or semipublic well in connection with the sale, exchange, purchase, or transfer of the real property that such well serves, shall[, not later than thirty days after the completion of such test,] report the test results [of such test] not later than thirty days after the completion of such test to (1) the [public] local health authority of the municipality where the property is located, and (2) the Department of Public Health in a format specified by the department[, provided such report shall only be required if the party for whom the]. The laboratory or firm [conducted such test informs the laboratory or firm identified] shall use the information provided on the chain of custody documentation submitted with the test samples [that the test was conducted in connection] to determine if the results are associated with the sale, exchange, purchase, or transfer of [such] the real property and are required to be reported to the local health authority and the Department of Public Health. [No regulation may require such a test to be conducted as a consequence or a condition of the sale, exchange, transfer, purchase or rental of the real property on which the private well or semipublic well is located.]

(d) Prior to the [sale, exchange, purchase, transfer or] rental of real property on which a private or semipublic well is located, the owner shall provide the [buyer or] tenant notice that educational material concerning private well testing is available on the Department of Public Health web site. Failure to provide such notice shall not invalidate any [sale, exchange, purchase, transfer or] rental of real property. [If the seller or landlord provides such notice in writing, the seller or landlord and any real estate licensee shall be deemed to have fully satisfied any duty to notify the buyer or tenant that the subject real property is located in an area for which there are reasonable grounds for testing under subsection (g) or (j) of this section] Testing for the following contaminants shall be required at the time of sale, exchange, purchase, or transfer of real property of all properties supplied by a private or semipublic well: total coliform, nitrate, nitrite, sodium, chloride, iron, manganese, hardness, turbidity, pH, sulfate, apparent color, odor, arsenic, and uranium. The cost of the water test shall be the

responsibility of the buyer.

(e) The Commissioner of Public Health shall adopt regulations, in accordance with chapter 54, to clarify the criteria under which the commissioner may issue a well permit exception and to describe the terms and conditions that shall be imposed when a well is allowed at a premises (1) that is connected to a public water supply system, or (2) whose boundary is located within two hundred feet of an approved community water supply system, measured along a street, alley or easement. Such regulations shall (A) provide for notification of the permit to the public water supplier, (B) address the quality of the water supplied from the well, the means and extent to which the well shall not be interconnected with the public water supply, the need for a physical separation, and the installation of a reduced pressure device for backflow prevention, the inspection and testing requirements of any such reduced pressure device, and (C) identify the extent and frequency of water quality testing required for the well supply.

(f) No regulation may require that a certificate of occupancy for a dwelling unit on such residential property be withheld or revoked on the basis of a water quality test performed on a private well pursuant to this section, unless such test results indicate that any maximum contaminant level applicable to public water supply systems for any contaminant listed in the regulations of Connecticut state agencies has been exceeded. No administrative agency, health district or municipal health officer may withhold or cause to be withheld such a certificate of occupancy except as provided in this section.

(g) The local director of health may require a private well or semipublic well to be tested for [arsenic,] radium, [uranium,] radon or gross alpha emitters, when there are reasonable grounds to suspect that such contaminants are present in the groundwater. For purposes of this subsection, "reasonable grounds" means (1) the existence of a geological area known to have naturally occurring [arsenic,] radium, [uranium,] radon or gross alpha emitter deposits in the bedrock; or (2) the well is located in an area in which it is known that [arsenic,] radium, [uranium,] radon or gross alpha emitters are present in the groundwater.

(h) Except as provided in subsection (i) of this section, the collection of samples for determining the water quality of private wells and semipublic wells may be made only by (1) employees of a laboratory or firm certified or approved by the Department of Public Health to test drinking water, if such employees have been trained in sample collection techniques, (2) certified water operators, (3) local health departments and state employees trained in sample collection techniques, or (4) individuals with training and experience that the Department of Public Health deems sufficient.

(i) Any owner of a residential construction, including, but not limited to, a homeowner, on which a private well is located or any general contractor of a new residential construction on which a private well is located may collect samples of well water for submission to a laboratory or firm for the purposes of testing water quality pursuant to this section, provided (1) such laboratory or firm has provided instructions to said owner or general contractor on how to collect such samples, and (2) such owner or general contractor is identified to the subsequent owner on a form to be prescribed by the Department of Public Health. No regulation may prohibit or impede such collection or analysis.

(j) The local director of health may require private wells and semipublic wells to be tested for pesticides, herbicides or organic chemicals when there are reasonable grounds to suspect that any such contaminants might be present in the groundwater. For purposes of this subsection, "reasonable grounds" means (1) the presence of nitrate-nitrogen in the groundwater at a concentration greater than ten milligrams per liter, or (2) that the private well or semipublic well is located on land, or in proximity to land, associated with the past or present production, storage, use or disposal of organic chemicals as identified in any public record.

(k) Any water transported in bulk by any means to a premises currently supplied by a private well or semipublic well where the water is to be used for purposes of drinking or domestic use shall be provided by a bulk water hauler licensed pursuant to section 20-278h. No bulk water hauler shall deliver water without first notifying the owner of the premises of such delivery. Bulk water hauling to a premises currently supplied by a private well or semipublic well shall be permitted only as a temporary measure to alleviate a water supply shortage.

Agency Legislative Proposal - 2022 Session

Document Name: 10.8.21 - DPH - Various Revisions – Revised November 19, 2021- Revised 12/3/2021

State Agency: Department of Public Health
Liaison: Brie Wolf / Jill Kennedy **Phone:** (860) 509-7246 / (860) 509-7280 **E-mail:** brie.wolf@ct.gov / jill.kennedy@ct.gov
Lead agency division requesting this proposal: Healthcare Quality and Safety Branch, Health Statistics and Surveillance Section, Environmental Health Section
Agency Analyst/Drafter of Proposal: Jill Kennedy and Brie Wolf

Title of Proposal: An Act Concerning Various Revisions to the Public Health Statutes
Statutory Reference: Section 1. 19a-490. Licensing of institutions. Definitions. Section 2. 19a-491c. Criminal history and patient abuse background search program. Regulations. Section 3. 19a-535b. Chronic disease hospital. Transfer or discharge of patients. Notice. Section 4. 19a-537. Definitions. Nursing home responsibilities re reservation of beds. Reimbursement. Readmission. Section 5. 19a-550. Patients' bill of rights. Section 6. 20-185r. Central service technicians. Definitions. Examination and credentials. Continuing education. Section 7. 12-20a. Grants in lieu of taxes on real property of private colleges, general hospitals, chronic disease hospitals and certain urgent care facilities. Section 8. 17b-368. Pilot project for diagnosis, care and treatment of persons with chronic or geriatric mental conditions. Section 9. 19a-491. License and certificate required. Application. Assessment of civil penalties or a consent order. Fees. Minimum service quality standards. Regulations. Professional liability insurance. Prohibition. Maintenance of medical records. Section 10. 19a-498. Inspections, investigations, examinations and audits. Retention of records. Section 11. 19a-509g. Alcohol or drug treatment facility. Criteria for admission. Section 12. 19a-491. License and certificate required. Application. Assessment of civil penalties or a consent order. Fees. Minimum service quality standards. Regulations. Professional liability insurance. Prohibition. Maintenance of medical records. Section 13. 19a-497. Filing of strike contingency plan. Summary order. Civil penalty: Notification and hearing requirement. Regulations. Collective bargaining implications.

Section 14. 19a-515 License renewal. Continuing education requirement.
Section 15. 19a-492e Delegation of medication administration by registered nurse to home health aide. Regulations.
Section 16. Sec. 19a-495a. Unlicensed assistive personnel in residential care homes. Certification re administration of medication. Regulations. Nonnursing duties.
Section 17. (NEW)
Section 18. 20-88. State Board of Examiners for Nursing.
Section 19. 20-90. Duties of the Board
Section 20. Sec. 19a-16d. Submission of scope of practice requests and written impact statements to Department of Public Health. Requests for exemption. Notification and publication of requests.
Section 21. Sec. 19a-16e. Scope of practice review committees. Membership. Duties.
Section 22. Sec. 20-132a. Definitions. Renewal of licenses. Continuing education. Exceptions.
Section 23. 19a-14c. Provision of outpatient mental health treatment to minors without parental consent.
Section 24. Subsection (b) of section 93 of Public Act 21-121
Section 25. 19a-177. Duties of commissioner.
Section 26. 14-1. Definitions.
Section 27. (NEW)
Section 28. (NEW)
Section 29. (NEW)
Section 30. (NEW)
Section 31. 17b-59e
Section 32. 19a-72. (Formerly Sec. 19-29a). Connecticut Tumor Registry. Definitions. Duties of Department of Public Health. Reporting requirements. Penalties. Regulations.
Section 33. 19a-110. Report of lead poisoning. Parental notification. Availability of information regarding lead poisoning.
Section 34. 19a-215. Commissioner's lists of reportable diseases, emergency illnesses and health conditions and reportable laboratory findings. Reporting requirements. Confidentiality. Fines.
Section 35. 19a-269b. Screening for kidney disease. Clinical laboratories.
Section 36. 19a-415a. Release of biologic material of a deceased person.
Section 37. 20-7a. Billing for clinical laboratory services. Cost of diagnostic tests. Financial disclosures to patients. Billing practices re anatomic pathology services.
Section 38. 20-7c. Access to medical records. Notification to patient of certain test results. Authority of provider to withhold information.
Section 39. 38a-477aa. Cost-sharing and health care provider reimbursements for emergency services and surprise bills.
Section 40. 38a-479aa. Preferred provider networks. Definitions. Licensing. Fees. Requirements. Exception, regulations.

Section 41. 51-164n. Procedure upon summons for infraction or certain violations. Payment by mail. Procedure at trial.
Section 42. 7-51a. Copies of vital records. Access to vital records by members of genealogical societies. Marriage and civil union licenses. Death certificates. Issuance of certified copies of electronically filed certificates.
Section 43. 7-74. Fees for certification of birth registration, certified copy of vital statistics certificate and uncertified copy of original certificate of birth. Waiver of fee for certificate of death for a veteran.
Section 44. 19a-36m. Authority of directors of health and Commissioner of Agriculture. Application of provisions of food code re certified food managers. Exceptions.
Section 45. 16-245n.
Section 46. 20-191c. Continuing education.
Section 47. Section 10 of public act 21-185
Section 48. Repealers: 19a-30, 19a-30a, 19a-31, 19a-31b

Proposal Summary:

Section 1. Makes technical revisions to the statutes pertaining to healthcare facilities to remove the term "alcohol or drug treatment facility" and add definitions for "chronic disease hospital" and "clinical laboratory."

Sections 2 through 8. Makes technical revisions to several sections of statute pertaining to chronic disease hospitals to refer to the section where the definition has been added.

Sections 9 through 11. Makes technical revisions to remove the term "alcohol or drug treatment facility" in several sections of statute.

Section 12. Makes a technical revision to add the Solnit Psychiatric Residential Treatment Facilities (PRTF's) to the list of facilities that require a license.

Section 13. Requires nursing home facilities to submit staffing plans as part of their strike contingency plan to the Department when they are notified of a strike within their facility.

Section 14. Requires nursing home administrators to take continuing education units (CEUs) in infection control.

Sections 15 and 16. Allow for DPH to accept medication administration certification from DCF and DDS for home health agencies and residential care homes.

Section 17. Requires DPH to convene a committee to conduct a scope of practice review for non-nurse midwives (e.g. certified professional midwives or direct entry midwives) in Connecticut to determine if the profession should be regulated.

Sections 18 and 19. Make technical revisions regarding the board of nursing.

Sections 20 and 21. Revise statutory deadlines for the healthcare professional scope of practice review process.

Section 22. Allows optometrists to complete six hours of their required continuing education units (CEUs) remotely.

Section 23. Makes a technical change to remove term "certified independent social worker"

Section 24. Makes a technical change from of "American Association of Physician Assistants" to "American Academy of Physician Assistants or a successor organization."
Section 25. Changes the reporting date for the Emergency Medical Services Data Report.
Section 26. Makes a technical change to the definition of "authorized emergency vehicle" in the Department of Motor Vehicles statute.
Sections 27 through 41. Moves sections relating to clinical laboratories (19a-30, 19a-30a, 19a-31 and 19a-31b) into Chapter 386v.
Sections 42 and 43. Move language that allows registrars of vital statistics to receive online payments to the correct section of statute.
Section 44. Allows certain entities to be almost completely exempt from the Food and Drug Administration (FDA) model food code requirements.
Section 45. Corrects a drafting error for a statutory reference.
Section 46. Revises the CEU's for physician assistants to update the language with current terminology.
Section 47. Revises section 10 of Public Act 21-185 to allow the Department to develop policies and procedures until regulations regarding staffing levels can be put in place.
Section 48. Repeals sections 19a-30, 19a-30a, 19a-31, 19a-31b of the general statutes.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

Section 1. Revises the statute pertaining to definitions for healthcare facilities, by removing the term "alcohol or drug treatment facility" and adding definitions of "chronic disease hospital" and "clinical laboratory."

Sections 2 through 8. Revise the different sections of statute that pertain to "chronic disease hospital" to ensure each definition referenced corresponds with the new definition referenced in Section 1. This will ensure consistency among statutes to avoid any confusion as to the appropriate definition of a chronic disease hospital. During the development of executive orders, the Department discovered that chronic disease hospitals were not defined in the same section of statute as other facility types. We also realized that throughout the statutes chronic disease hospitals had slightly different definitions.

Sections 9 through 11. Currently, the Department licenses behavioral health facilities, which is a broad definition of facility types for behavioral, and substance use services. The standalone definition of alcohol or drug treatment facility is no longer needed because they fall under the definition of a behavioral health facility. The Department has been working to update statutes pertaining to behavioral health facilities over the last few years. This proposal will remove the definition of "alcohol or drug treatment facility" and the corresponding statutes.

Section 12. Makes a technical revision to add the Solnit PRTFs to the list of facilities that require a license. Sections 29 through 31 of Public Act 21-2 of the June Special Session, calls for DPH licensure of Solnit PRTF facilities. The Act also requires the Department to develop regulations to and begin licensing these facilities by October 1, 2022. This technical revision is needed to move forward with the regulations.

Section 13. Requires nursing homes to provide staffing plans for a minimum of three days staffing at least five days prior to a strike commencing at the facility. During the last potential strike, the Department ran into issues with nursing homes not planning staffing appropriately during a strike, which may have led to facilities not having enough staff to care for the residents.

Section 14. During the COVID-19 pandemic, nursing homes were often short staffed and the Department found that nursing home administrators, who may not have any clinical or public health education or experience, were serving as infection control support persons for the facility. The CEU requirement will ensure nursing home administrators have foundational knowledge of infection control measures.

Sections 15 and 16. The Department has been participating on a multi-agency taskforce to streamline licensure and certification processes between DPH, DMHAS, DDS, and DCF. One goal is to allow the medication certification training for unlicensed individuals to be accepted across DPH/DDS/DCF. The agencies have worked together to develop a basic training program that is acceptable to all agencies. Once basic certification is earned, individuals may have to take a specialized program depending on for which agency they are working.

Section 17. Connecticut is one of 16 states and the District of Columbia that does not regulate the practice of midwifery performed by non-nurse midwives, according to the Midwives Alliance of North America. The Department occasionally receives calls from hospitals and OB/GYNs or pediatric providers with concerns about the care provided by a midwife, yet there is no mechanism to regulate midwifery practiced by a non-nurse midwife. There are no state restrictions on who can call themselves a midwife or practice midwifery in Connecticut; except for nurse midwives. The Department thinks that a scope of practice-like process, which includes

individuals from the profession and others involved in maternal and child health, is the best option to provide guidance to assist the legislature in establishing a regulatory framework for this profession. The Department is open to various regulatory options to regulate health care professionals like midwives. The range of options include: 1) codifying in statute that nobody may call themselves a midwife unless they are certified by one of several organizations (i.e. statutory recognition); 2) establishing a registry of midwives who are certified by organizations; 3) state certification of midwives; and 4) licensure of midwives.

Section 18. Removes language requiring the nursing board to record meetings. Currently, the Department records all meetings. The revision codifies current practice to allow the Department to continue to do so, as requested by the board.

Section 19. Removes language requiring DPH to promulgate regulations pertaining to high school adult education nursing programs as these programs have all been closed. Codifies existing practice by clarifying the nursing board has the authority to approve or disapprove nursing schools that have been inspected by DPH. Requires DPH, instead of the nursing board, to provide a list of all educational programs for RN's and LPN's to anyone who requests. The Department has been maintaining the list for the board for many years and will continue to maintain the list of programs and post the list on the Department's website.

Sections 20 and 21. Adjusts the timeframes for the scope of practice review process outlined in statute. The revisions will shorten the time by two weeks for each of the following: 1) DPH notification to the General Assembly of scope requests received and DPH posting requests filed on our internet website; 2) interested parties' response to the scope of practice review request submitted to DPH; and 3) DPH establishing and appointing members to a scope of practice review committee. This will allow more time for the committee to conduct their work and will offer more time for DPH to issue a report in the committee's findings and recommendations.

Section 22. The optometry continuing education unit (CEU) language is the most restrictive of all professions. The revision would expressly allow an optometrist to complete six of their ten CEU hours remotely.

Section 23. The statute that allows counseling of minors without parental consent lists "certified independent social worker" as a qualified professional permitted to conduct the counseling. This licensure category has not existed in Connecticut statute since 1995. The language will be amended to read "licensed clinical social worker."

Section 24. Section 93 of Public Act 21-121, listed an incorrect organization in the section pertaining to CEU's for physician assistants. The revision makes a technical change from of "American Association of Physician Assistants" to "American Academy of Physician Assistants or a successor organization."

Section 25. The Emergency Medical Services (EMS) Data report is due annually on December 31st to the Connecticut Emergency Medical Services Advisory Board (CEMSAB). Extending the reporting requirement to April 1st would allow DPH the time to review and analyze the data provided to the Department quarterly by EMS organizations, and submit to CEMSAB a comprehensive report within a realistic timeframe.

Section 26. Section 35 of Public Act 21-106 modifies the definition of "authorized emergency vehicle" to only include a fire department vehicle, police vehicle or an ambulance for types of vehicles that can use lights and sirens. However, often paramedic intercept vehicles or other types of emergency medical services, known as "fly cars" arrive at a scene to help respond to an EMS call. The Department is revising the definition to match the term "authorized emergency medical services vehicles" in section 19a-170, to ensure all EMS vehicles are included in this section of statute.

Sections 27 to 42. Move several sections of statute (19a-30, 19a-30a, 19a-31 and 19a-31b) that pertain to clinical laboratory licensing into the "healthcare institution" licensing section of statute, and moves any other related language to chapter 368v (healthcare facilities). Having language pertaining to clinical laboratories in other sections of statue is an oversight that the Department would like to correct, since they are a regulated facility type.

Sections 42 and 43. Public Act 21-2, JSS, included language to modernize public services. Section 156 of the Act allows registrars of vital statistics to receive online payments, but the language was put in the wrong section of statute. This proposal moves the language to the correct section of statute.

Section 44. Current statutory language allows a bed and breakfast, or educational, religious, political or charitable organization's bake sale or potluck supper, to comply with the FDA model food code, but exempts these organizations from employing a certified food protection manager and complying with certain reporting requirements. The language will be revised to allow these entities to be almost completely exempt from following the model food code. We are doing this to honor the intent of laws that passed in years prior. Public Act 95-44 prohibited regulating the sale of food at a noncommercial function. Public Act 09-7, SSS, expanded the exemption to include persons distributing food and outlined that distribution or sale of food at a "noncommercial function" is by a person not normally engaged in the business of selling such food for profit. Food served at noncommercial function must still be maintained at the temperature, pH level and water activity level conditions that will inhibit the growth of infectious or toxigenic microorganisms.

Section 45. Revises a drafting error that was made in Public Act 21-115 to change a statutory reference from 22a-438f, to 22a-483f.

Section 46. Revises the language pertaining to physician assistants to correct outdated terms by adding the wording "nonsynchronous and synchronous."
Section 47. Section 10 of Public Act 21-185 madates the Department to develop and implement policies and procedures regarding staffing levels, including increasing social worker hours in nursing homes by January 1, 2022. The Department is unable to comply with this request by the due date. This revision will allow the Department to develop policies and procedures until regulations can be put in place.

Section 48. Repeals sections 19a-30, 19a-30a, 19a-31, 19a-31b of the general statutes.

◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Department of Revenue Services – Section 7
Agency Contact (*name, title, phone*): Sue Sherman and Ernie Adamo
Date Contacted:

Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**

Summary of Affected Agency's Comments
Click here to enter text.

Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Social Services – Sections 8, 31 **Agency Contact (*name, title, phone*):** Alvin Wilson and David Seifel **Date Contacted:** Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Mental Health and Addiction Services – Section 10 **Agency Contact (*name, title, phone*):** Mary Kate Mason **Date Contacted:** Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Children and Families – Sections 12, 15, 16 **Agency Contact (*name, title, phone*):** Vincent Russo **Date Contacted:** Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Developmental Services – Sections 15 and 16 **Agency Contact (*name, title, phone*):** Rod O'Connor **Date Contacted:** Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**
Agency Name: Department of Motor Vehicles – Section 26 **Agency Contact (*name, title, phone*):** Katherine Grady **Date Contacted:** Section 26 Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Insurance – Sections 39, 40 **Agency Contact (*name, title, phone*):** Lady Mendoza **Date Contacted:** Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Judicial Branch – Section 41 **Agency Contact (*name, title, phone*):** Brittany Kaplan **Date Contacted:** Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☒**NO**
Agency Name: Department of Administrative Services – Sections 42 and 43 **Agency Contact (*name, title, phone*):** Eleanor Michael and Lee Ross **Date Contacted:** Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☒**NO**

Agency Name: Department of Consumer Protection – Section 44 **Agency Contact (*name, title, phone*):** Leslie O'Brien **Date Contacted:** Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☒**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)* None
State None
Federal None
Additional notes on fiscal impact None

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

Please see Reason for Proposal section

◊ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs. Section 11. There is currently no regulatory oversight of non-nurse midwives in Connecticut. The Department anticipates that this legislation would establish a minimum baseline training for anyone who calls themselves a midwife and offers their services to families. The Department is open to the various regulatory options that are available to regulate health care professionals like midwives. The direct entry midwives are licensed or certified to practice in the following 34 states: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, Florida, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Montana, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and Wyoming: https://mana.org/about-midwives/state-by-state.

Section 1. Section 19a-490 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(a) "Institution" means a hospital, short-term hospital special hospice, hospice inpatient facility, residential care home, nursing home facility, home health care agency, hospice agency, home health aide agency, behavioral health facility, assisted living services agency, outpatient surgical facility, outpatient clinic, clinical laboratory, an infirmary operated by an educational institution for the care of students enrolled in, and faculty and employees of, such institution; a facility engaged in providing services for the prevention, diagnosis, treatment or care of human health conditions, including facilities operated and maintained by any state agency; and a residential facility for persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disability. "Institution" does not include any facility for the care and treatment of persons with mental illness or substance use disorder operated or maintained by any state agency, except Whiting Forensic Hospital;

(b) "Hospital" means an establishment for the lodging, care and treatment of persons suffering from disease or other abnormal physical or mental conditions and includes inpatient psychiatric services in general hospitals;

(c) "Residential care home" or "rest home" means a community residence that furnishes, in single or multiple facilities, food and shelter to two or more persons unrelated to the proprietor and, in addition, provides services that meet a need beyond the basic provisions of food, shelter and laundry and may qualify as a setting that allows residents to receive home and community-based services funded by state and federal programs;

(d) "Home health care agency" means a public or private organization, or a subdivision thereof, engaged in providing professional nursing services and the following services, available twenty-four hours per day, in the patient's home or a substantially equivalent environment: Home health aide services as defined in this section, physical therapy, speech therapy, occupational therapy or medical social services. The agency shall provide professional nursing services and at least one additional service directly and all others directly or through contract. An agency shall be available to enroll new patients seven days a week, twenty-four hours per day;

(e) "Home health aide agency" means a public or private organization, except a home health care agency, which provides in the patient's home or a substantially equivalent environment supportive services which may include, but are not limited to, assistance with personal hygiene, dressing, feeding and incidental household tasks essential to achieving adequate household and family management. Such supportive services shall be provided under the supervision of a registered nurse and, if such nurse determines appropriate, shall be provided by a social worker, physical therapist, speech therapist or occupational therapist. Such supervision may be provided directly or through contract;

(f) "Home health aide services" as defined in this section shall not include services provided to assist individuals with activities of daily living when such individuals have a disease or condition that is chronic and stable as determined by a physician licensed in the state;

(g) "Behavioral health facility" means any facility that provides mental health services to persons eighteen years of age or older or substance use disorder services to persons of any age in an outpatient treatment or residential setting to ameliorate mental, emotional, behavioral or substance use disorder issues;

[(h) "Alcohol or drug treatment facility" means any facility for the care or treatment of persons suffering from alcoholism or other drug addiction;]

[(i)] (h) "Person" means any individual, firm, partnership, corporation, limited liability company or association;

[(j)] (i) "Commissioner" means the Commissioner of Public Health or the commissioner's designee;

[(k)] (j) "Home health agency" means an agency licensed as a home health care agency or a home health aide agency;

[(l)] (k) "Assisted living services agency" means an agency that provides, among other things, nursing services and assistance with activities of daily living to a population that is chronic and stable and that may have a dementia special care unit or program as defined in section 19a-562, as amended by this act;
[(m)] (l) "Outpatient clinic" means an organization operated by a municipality or a corporation, other than a hospital, that provides (1) ambulatory medical care, including preventive and health promotion services, (2) dental care, or (3) mental health services in conjunction with medical or dental care for the purpose of diagnosing or treating a health condition that does not require the patient's overnight care;

[(n)] (m) "Multicare institution" means a hospital that provides outpatient behavioral health services or other health care services, psychiatric outpatient clinic for adults, free-standing facility for the care or treatment of substance abusive or dependent persons, hospital for psychiatric disabilities, as defined in section 17a-495, or a general acute care hospital that provides outpatient behavioral health services that (1) is licensed in accordance with this chapter, (2) has more than one facility or one or more satellite units owned and operated by a single licensee, and (3) offers complex patient health care services at each facility or satellite unit. For purposes of this subsection, "satellite unit" means a location where a segregated unit of services is provided by the multicare institution;

[(o)] (n) "Nursing home" or "nursing home facility" 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 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;

[(p)] (o) "Outpatient dialysis unit" means (1) an out-of-hospital out-patient dialysis unit that is licensed by the department to provide (A) services on an out-patient basis to persons requiring dialysis on a short-term basis or for a chronic condition, or (B) training for home dialysis, or (2) an in-hospital dialysis unit that is a special unit of a licensed hospital designed, equipped and staffed to (A) offer dialysis therapy on an outpatient basis, (B) provide training for home dialysis, and (C) perform renal transplantations; [and]

[(q)] (p) "Hospice agency" means a public or private organization that provides home care and hospice services to terminally ill patients[.];

(q) "clinical laboratory" means any facility or other area used for microbiological, serological, chemical, hematological, immunohematological, biophysical, cytological, pathological or other examinations of human body fluids, secretions, excretions or excised or exfoliated tissues, for the purpose of providing information for the diagnosis, prevention or treatment of any human disease or impairment, for the assessment of human health or for the presence of drugs, poisons or other toxicological substances; and

(r) "Chronic disease hospital" means a long-term hospital having facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of chronic diseases.

Section 2. Subsection (a) of section 19a-491c is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(a) As used in this section:

(1) "Criminal history and patient abuse background search" or "background search" means (A) a review of the registry of nurse's aides maintained by the Department of Public Health pursuant to section 20-102bb, (B) checks of state and national criminal history records conducted in accordance with section 29-17a, and (C) a review of any other registry specified by the Department of Public Health which the department deems necessary for the administration of a background search program.

(2) “Direct access” means physical access to a patient or resident of a long-term care facility that affords an individual with the opportunity to commit abuse or neglect against or misappropriate the property of a patient or resident.

(3) “Disqualifying offense” means a conviction of (A) any crime described in 42 USC 1320a-7(a)(1), (2), (3) or (4), (B) a substantiated finding of neglect, abuse or misappropriation of property by a state or federal agency pursuant to an investigation conducted in accordance with 42 USC 1395i-3(g)(1)(C) or 42 USC 1396r(g)(1)(C), or (C) a conviction of any crime described in section 53a-59a, 53a-60b, 53a-60c, 53a-61a, 53a-321, 53a-322 or 53a-323.

(4) “Long-term care facility” means any facility, agency or provider that is a nursing home, as defined in section 19a-521, a residential care home, as defined in section 19a-521, a home health agency, as defined in section 19a-490, an assisted living services agency, as defined in section 19a-490, an intermediate care facility for individuals with intellectual disabilities, as defined in 42 USC 1396d(d), except any such facility operated by a Department of Developmental Services' program subject to background checks pursuant to section 17a-227a, a chronic disease hospital, as defined in section [19a-550] 19a-490, or an agency providing hospice care which is licensed to provide such care by the Department of Public Health or certified to provide such care pursuant to 42 USC 1395x.

Section 3. Subsection (a) of section 19a-535b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

[(a) As used in this section, a “facility” means a chronic disease hospital which is a long-term hospital having facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of chronic diseases.]

[(b)] (a) A [facility] chronic disease hospital shall not transfer or discharge a patient from the [facility] chronic disease hospital except for medical reasons, or for the patient's welfare or the welfare of other patients, as documented in the patient's medical record; or, in the case of a self pay patient, for nonpayment or arrearage of more than fifteen days of the per diem chronic disease hospital room rates for the patient's stay, except as prohibited by the Social Security Act. In the case of an involuntary transfer or discharge, the patient and, if known, the patient's legally liable relative, guardian or conservator and the patient's personal physician, if the discharge plan is prepared by the medical director of the chronic disease hospital, shall be given at least thirty days' written notice of the proposed action to ensure orderly transfer or discharge.

Section 4. Section 19a-537 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(a) As used in this section and section 19a-537a:

(1) “Vacancy” means a bed that is available for an admission;

(2) “Nursing home” means any chronic and convalescent facility or any rest home with nursing supervision, as defined in section 19a-521;

(3) “Hospital” means a general short-term hospital licensed by the Department of Public Health or a hospital for mental illness, as defined in section 17a-495, or a chronic disease hospital, as defined in section [19-13-D1(a) of the Public Health Code] 19a-490.

Section 5. Section 19a-550 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(a)(1) As used in this section, (A) “nursing home facility” has the same meaning as provided in section 19a-521, (B) “residential care home” has the same meaning as provided in section 19a-521, and (C) “chronic disease hospital” [means a long-term hospital having facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of chronic diseases] has the same meaning as provided in section 19a-490; and (2) for the purposes of subsections (c) and (d) of this section, and subsection

(b) of section 19a-537, “medically contraindicated” means a comprehensive evaluation of the impact of a potential room transfer on the patient's physical, mental and psychosocial well-being, which determines that the transfer would cause new symptoms or exacerbate present symptoms beyond a reasonable adjustment period resulting in a prolonged or significant negative outcome that could not be ameliorated through care plan intervention, as documented by a physician or an advanced practice registered nurse in a patient's medical record.

Section 6. Subsection (a) of section 20-185r is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(a) As used in this section:

(1) "Central service technician" means a person who decontaminates, inspects, assembles, packages and sterilizes reusable medical instruments or devices in a health care facility, whether such person is employed by the health care facility or provides services pursuant to a contract with the health care facility;

(2) "Health care facility" means an outpatient surgical facility, as defined in section 19a-493b, or a hospital, as defined in section 19a-490, but does not include a chronic disease hospital, as defined in section [19a-550] 19a-490;

(3) "Health care provider" means a person or organization that provides health care services and is licensed in accordance with this title; and

(4) "Central service department" means a department within a health care facility that processes, issues and controls medical supplies, devices and equipment, both sterile and nonsterile, for patient care areas of a health care facility.

(b) Unless otherwise permitted pursuant to this section, no person shall practice as a central service technician unless such person (1) (A) has successfully passed a nationally accredited central service exam for central service technicians and holds and maintains one of the following credentials: (i) A certified registered central service technician credential administered by the International Association of Healthcare Central Service Materiel Management, or (ii) a certified sterile processing and distribution technician credential administered by the Certification Board for Sterile Processing and Distribution, Inc., or (B) was employed or otherwise contracted for services as a central service technician in a health care facility before January 1, 2016, or (2) obtains a certified registered central service technician credential administered by the International Association of Healthcare Central Service Materiel Management or a certified sterile processing and distribution technician credential administered by the Certification Board for Sterile Processing and Distribution, Inc., not later than two years after such person's date of hire or contracting for services with the health care facility.

Section 7. Section 12-20a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(a) Until the fiscal year commencing July 1, 2016, on or before January first, annually, the Secretary of the Office of Policy and Management shall determine the amount due to each municipality in the state, in accordance with this section, as a state grant in lieu of taxes with respect to real property owned by any private nonprofit institution of higher learning or any nonprofit general hospital facility or freestanding chronic disease hospital or an urgent care facility that operates for at least twelve hours a day and that had been the location of a nonprofit general hospital for at least a portion of calendar year 1996 to receive payments in lieu of taxes for such property, exclusive of any such facility operated by the federal government, except a campus of the United States Department of Veterans Affairs Connecticut Healthcare Systems, or the state of Connecticut or any subdivision thereof. As used in this section, "private nonprofit institution of higher learning" means any such institution, as defined in subsection (a) of section 10a-34, or any independent institution of higher education, as defined in subsection (a) of section 10a-173, that is engaged primarily in education beyond the high school level,

and offers courses of instruction for which college or university-level credit may be given or may be received by transfer, the property of which is exempt from property tax under any of the subdivisions of section 12-81; "nonprofit general hospital facility" means any such facility that is used primarily for the purpose of general medical care and treatment, exclusive of any hospital facility used primarily for the care and treatment of special types of disease or physical or mental conditions; and "freestanding chronic disease hospital" [means a facility that provides for the care and treatment of chronic diseases excluding,] has the same meaning as "chronic disease hospital" in section 19a-490, exclusive of any such facility having an ownership affiliation with and operated in the same location as a chronic and convalescent nursing home.

Section 8. Section 17b-368 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

On or before July 1, 2004, the Department of Social Services shall, within the limits of available Medicaid funding, implement a pilot project in Greater Hartford with chronic disease hospital colocated with a skilled nursing facility and with the facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of chronic or geriatric mental conditions that require prolonged hospital or restorative care. For purposes of this section, "chronic disease hospital" [means a long-term hospital with facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of chronic physical and geriatric mental health conditions that require prolonged hospital or restorative care] has the same meaning as provided in section 19a-490.

Section 9. Subsection (b) of section 19a-491 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(b) If any person acting individually or jointly with any other person owns real property or any improvements thereon, upon or within which an institution, as defined in subsections (c) and [(o)] (n) of section 19a-490, is established, conducted, operated or maintained and is not the licensee of the institution, such person shall submit a copy of the lease agreement to the department at the time of any change of ownership and with each license renewal application. The lease agreement shall, at a minimum, identify the person or entity responsible for the maintenance and repair of all buildings and structures within which such an institution is established, conducted or operated. If a violation is found as a result of an inspection or investigation, the commissioner may require the owner to sign a consent order providing assurances that repairs or improvements necessary for compliance with the provisions of the Public Health Code shall be completed within a specified period of time or may assess a civil penalty of not more than one thousand dollars for each day that such owner is in violation of the Public Health Code or a consent order. A consent order may include a provision for the establishment of a temporary manager of such real property who has the authority to complete any repairs or

improvements required by such order. Upon request of the Commissioner of Public Health, the Attorney General may petition the Superior Court for such equitable and injunctive relief as such court deems appropriate to ensure compliance with the provisions of a consent order. The provisions of this subsection shall not apply to any property or improvements owned by a person licensed in accordance with the provisions of subsection (a) of this section to establish, conduct, operate or maintain an institution on or within such property or improvements.

Section 10. Section 19a-498 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(a) Subject to the provisions of section 19a-493, the Department of Public Health shall make or cause to be made a biennial licensure inspection of all institutions and such other inspections and investigations of institutions and examination of their records as the department deems necessary.

(b) The commissioner, or an agent authorized by the commissioner to conduct any inquiry, investigation or hearing under the provisions of this chapter, shall have power to inspect the premises of an institution, issue subpoenas, order the production of books, records or documents, administer oaths and take testimony under oath relative to the matter of such inquiry, investigation or hearing. At any hearing ordered by the department, the commissioner or such agent may subpoena witnesses and require the production of records, papers and documents pertinent to such inquiry. If any person disobeys such subpoena or, having appeared in obedience thereto, refuses to answer any pertinent question put to such person by the commissioner or such agent or to produce any records and papers pursuant to the subpoena, the commissioner or such agent may apply to the superior court for the judicial district of Hartford or for the judicial district wherein the person resides or wherein the business has been conducted, setting forth such disobedience or refusal, and said court shall cite such person to appear before said court to answer such question or to produce such records and papers.

(c) The Department of Mental Health and Addiction Services, with respect to any behavioral health facility [or alcohol or drug treatment facility], shall be authorized, either upon the request of the Commissioner of Public Health or at such other times as they deem necessary, to enter such facility for the purpose of inspecting programs conducted at such facility. A written report of the findings of any such inspection shall be forwarded to the Commissioner of Public Health and a copy shall be maintained in such facility's licensure file.

(d) In addition, when the Commissioner of Social Services deems it necessary, said commissioner, or a designated representative of said commissioner, may examine and audit the financial records of any nursing home facility, as defined in section 19a-521, any residential care home, as defined in section 19a-521, or any nursing facility management services certificate holder, as defined in section 19a-561. Each nursing home facility, residential care home and nursing facility management services certificate

holder shall retain all financial information, data and records relating to the operation of the nursing home facility or residential care home for a period of not less than ten years, and all financial information, data and records relating to any real estate transactions affecting such operation, for a period of not less than twenty-five years, which financial information, data and records shall be made available, upon request, to the Commissioner of Social Services or such designated representative at all reasonable times. In connection with any inquiry, examination or investigation, the commissioner or the commissioner's designated representative may issue subpoenas, order the production of books, records and documents, administer oaths and take testimony under oath. The Attorney General, upon request of said commissioner or the commissioner's designated representative, may apply to the Superior Court to enforce any such subpoena or order.

Section 11. Subsection (a) of section 19a-509g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

Commented [KJ1]:

(a) [An alcohol or drug treatment facility] A behavioral health facility, as defined in section 19a-490, that is licensed to provide substance use services shall use the criteria for admission developed by the American Society of Addiction Medicine for purposes of assessing a person for admission to such facility in consideration of (1) the services for which the facility is licensed, and (2) the appropriate services required for treatment of such person.

Section 12. Subsection (a) of section 19a-491 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) No person acting individually or jointly with any other person shall establish, conduct, operate or maintain an institution in this state without a license as required by this chapter, except for persons issued a license by the Commissioner of Children and Families pursuant to section 17a-145, which does not include the hospital and psychiatric residential treatment facility units of the Albert J. Solnit Children's Center, for the operation of (1) a substance abuse treatment facility, or (2) a facility for the purpose of caring for women during pregnancies and for women and their infants following such pregnancies. Application for such license shall (A) be made to the Department of Public Health upon forms provided by it, (B) be accompanied by the fee required under subsection (c), (d) or (e) of this section, (C) contain such information as the department requires, which may include affirmative evidence of ability to comply with reasonable standards and regulations prescribed under the provisions of this chapter, and (D) not be required to be notarized. The commissioner may require as a condition of licensure that an applicant sign a consent order providing reasonable assurances of compliance with the Public Health Code. The commissioner may issue more than one chronic disease hospital license to a single institution until such time as the state offers a rehabilitation hospital license.

Section 13. Section 19a-497 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(a) Each institution shall, upon receipt of a notice of intention to strike by a labor organization representing the employees of such institution, in accordance with the provisions of the National Labor Relations Act, 29 USC 158, file a strike contingency plan with the commissioner not later than five days before the date indicated for the strike.

(b) Each institution shall, as part of their strike contingency plan, submit to the Department their staffing plans, including the names of the individuals who will be providing services to the agency during the strike for a minimum of the first three days of staffing and their titles, not later than five days of receiving a notice of intention to strike by a labor organization representing the employees of the institution.

[(b)] (c) The commissioner may issue a summary order to any nursing home facility, as defined in section 19a-521, or any residential care home, as defined in section 19a-521, that fails to file a strike contingency plan that complies with the provisions of this section and the regulations adopted by the commissioner pursuant to this section within the specified time period. Such order shall require the nursing home facility or residential care home to immediately file a strike contingency plan that complies with the provisions of this section and the regulations adopted by the commissioner pursuant to this section.

[(c)] (d) Any nursing home facility or residential care home that is in noncompliance with this section shall be subject to a civil penalty of not more than ten thousand dollars for each day of noncompliance.

[(d)] (e) (1) If the commissioner determines that a nursing home facility or residential care home is in noncompliance with this section or the regulations adopted pursuant to this section, for which a civil penalty is authorized by subsection (c) of this section, the commissioner may send to an authorized officer or agent of the nursing home facility or residential care home, by certified mail, return receipt requested, or personally serve upon such officer or agent, a notice that includes: (A) A reference to this section or the section or sections of the regulations involved; (B) a short and plain statement of the matters asserted or charged; (C) a statement of the maximum civil penalty that may be imposed for such noncompliance; and (D) a statement of the party's right to request a hearing to contest the imposition of the civil penalty.

(2) A nursing home facility or residential care home may make written application for a hearing to contest the imposition of a civil penalty pursuant to this section not later than twenty days after the date such notice is mailed or served. All hearings under this section shall be conducted in accordance

with the provisions of chapter 54. If a nursing home facility or residential care home fails to request a hearing or fails to appear at the hearing or if, after the hearing, the commissioner finds that the nursing home facility or residential care home is in noncompliance, the commissioner may, in the commissioner's discretion, order that a civil penalty be imposed that is not greater than the penalty stated in the notice. The commissioner shall send a copy of any order issued pursuant to this subsection by certified mail, return receipt requested, to the nursing home facility or residential care home named in such order.

[(e)] (f) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54: (1) Establishing requirements for a strike contingency plan, which shall include, but not be limited to, a requirement that the plan contain documentation that the institution has arranged for adequate staffing and security, food, pharmaceuticals and other essential supplies and services necessary to meet the needs of the patient population served by the institution in the event of a strike; and (2) for purposes of the imposition of a civil penalty upon a nursing home facility or residential care home pursuant to subsections (c) and (d) of this section.

[(f)] (g) Such plan shall be deemed a statement of strategy or negotiation with respect to collective bargaining for the purpose of subdivision (9) of subsection (b) of section 1-210.

Section 14. Section 19a-515 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Each nursing home administrator's license issued pursuant to the provisions of sections 19a-511 to 19a-520, inclusive, shall be renewed once every two years, in accordance with section 19a-88, except for cause, by the Department of Public Health, upon forms to be furnished by said department and upon the payment to said department, by each applicant for license renewal, of the sum of two hundred five dollars. Each such fee shall be remitted to the Department of Public Health on or before the date prescribed under section 19a-88. Such renewals shall be granted unless said department finds the applicant has acted or failed to act in such a manner or under such circumstances as would constitute grounds for suspension or revocation of such license.

(b) Each licensee shall complete a minimum of forty hours of continuing education every two years, including, but not limited to, training in Alzheimer's disease and dementia symptoms and care as well as infection prevention and control. Such two-year period shall commence on the first date of renewal of the licensee's license after January 1, 2004. The continuing education shall be in areas related to the licensee's practice. Qualifying continuing education activities are courses offered or approved by the Connecticut Association of Healthcare Facilities, LeadingAge Connecticut, Inc., the Connecticut Assisted Living Association, the Connecticut Alliance for Subacute Care, Inc., the Connecticut Chapter of the American College of Health Care Administrators, the Association For Long Term Care Financial

Managers, the Alzheimer's Association or any accredited college or university, or programs presented or approved by the National Continuing Education Review Service of the National Association of Boards of Examiners of Long Term Care Administrators, Association for Professionals in Infection Control and Epidemiology or by federal or state departments or agencies.

(c) Each licensee shall obtain a certificate of completion from the provider of the continuing education for all continuing education hours that are successfully completed and shall retain such certificate for a minimum of three years. Upon request by the department, the licensee shall submit the certificate to the department. A licensee who fails to comply with the continuing education requirements shall be subject to disciplinary action pursuant to section 19a-517.

(d) The continuing education requirements shall be waived for licensees applying for licensure renewal for the first time. The department may, for a licensee who has a medical disability or illness, grant a waiver of the continuing education requirements for a specific period of time or may grant the licensee an extension of time in which to fulfill the requirements.

Section 15. Subsection (a) of section 19a-492e of the general statutes, as amended by Public Act 21-121, is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(a) For purposes of this section "home health care agency" and "hospice agency" have the same meanings as provided in section 19a-490, as amended by this act. Notwithstanding the provisions of chapter 378, a registered nurse may delegate the administration of medications that are not administered by injection to home health aides and hospice aides who have obtained certification and recertification every three years thereafter for medication administration in accordance with regulations adopted pursuant to subsection (b) of this section, or a current certification from the Departments of Children and Families or Developmental Services unless the prescribing practitioner specifies that a medication shall only be administered by a licensed nurse. [Any home health aide or hospice aide who obtained certification in the administration of medications on or before June 30, 2015, shall obtain recertification on or before July 1, 2018.]

Section 16. Section 19a-495a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(a)(1) The Commissioner of Public Health may adopt regulations, as provided in subsection (d) of this section, to require each residential care home, as defined in section 19a-490, that admits residents requiring assistance with medication administration, to (A) designate unlicensed personnel to obtain

certification, through the Department of Public Health, the Department of Children and Families or the Department of Developmental Services, for the administration of medication, and (B) ensure that such unlicensed personnel receive such certification and recertification every three years thereafter from the Departments of Public Health, Children and Families or Developmental Services.

(2) Any regulations adopted pursuant to this subsection shall establish criteria to be used by such homes in determining (A) the appropriate number of unlicensed personnel who shall obtain such certification and recertification, and (B) training requirements, including ongoing training requirements for such certification and recertification.

(3) Training requirements for initial certification and recertification shall include, but shall not be limited to: Initial orientation, resident rights, identification of the types of medication that may be administered by unlicensed personnel, behavioral management, personal care, nutrition and food safety, and health and safety in general.

(b) Each residential care home, as defined in section 19a-490, shall ensure that an appropriate number of unlicensed personnel, as determined by the residential care home, obtain certification and recertification, through the Department of Public Health, the Department of Children and Families or the Department of Developmental Services, for the administration of medication. Certification and recertification of such personnel shall be in accordance with any regulations adopted pursuant to this section[, except any personnel who obtained certification in the administration of medication on or before June 30, 2015, shall obtain recertification on or before July 1, 2018]. Unlicensed personnel obtaining such certification and recertification may administer medications that are not administered by injection to residents of such homes, unless a resident's physician specifies that a medication only be administered by licensed personnel.

(c) On and after October 1, 2007, unlicensed assistive personnel employed in residential care homes, as defined in section 19a-490, may (1) obtain and document residents' blood pressures and temperatures with digital medical instruments that (A) contain internal decision-making electronics, microcomputers or special software that allow the instruments to interpret physiologic signals, and (B) do not require the user to employ any discretion or judgment in their use; (2) obtain and document residents' weight; and (3) assist residents in the use of glucose monitors to obtain and document their blood glucose levels.

(d) The Commissioner of Public Health shall implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Section 17. (NEW) (*Effective from passage*):

The Commissioner of Public Health shall conduct a scope of practice review pursuant to sections 19a-16d to 19a-16f, inclusive, of the general statutes to determine whether the Department of Public Health should regulate midwives who are not eligible for licensure as a nurse-midwife as defined in Chapter 377 of the General Statutes. The commissioner shall report, in accordance with the provisions of section 11-4a of the general statutes, the findings of such committee and any recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health on or before February 1, 2023.

Section 18. Subsection (b) of section 20-88 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) The Governor shall appoint a chairperson from among such members. Said board shall meet at least once during each calendar quarter and at such other times as the chairman deems necessary. Special meetings shall be held on the request of a majority of the board after notice in accordance with the provisions of section 1-225. A majority of the members of the board shall constitute a quorum. Members shall not be compensated for their services. Any member who fails to attend three consecutive meetings or who fails to attend fifty per cent of all meetings held during any calendar year shall be deemed to have resigned from office. Minutes of all meetings shall be recorded by the [board] the Department as requested by the board. No member shall participate in the affairs of the board during the pendency of any disciplinary proceedings by the board against such member.

Section 19. Section 20-90 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Said board may adopt a seal.

(b) [The Commissioner of Public Health, with advice and assistance from the board, and in consultation with the State Board of Education, shall adopt regulations, in accordance with the provisions of chapter 54, permitting and setting standards for courses for the training of practical nurses to be offered in high schools or by the Technical Education and Career System for students who have not yet acquired a high school diploma. Students who satisfactorily complete courses approved by said Board of Examiners for Nursing, with the consent of the Commissioner of Public Health, as meeting such standards shall be given credit for each such course toward the requirements for a practical nurse's license.] All schools of nursing in this state[, except such schools accredited by the National League for Nursing or other professional accrediting association approved by the United States Department of Education and

recognized by the Commissioner of Public Health, and all schools for training licensed practical nurses and all hospitals connected to such schools] that prepare persons for examination under the provisions of this chapter, shall be:

(1) visited periodically by a representative of the Department of Public Health who shall be a registered nurse or a person experienced in the field of nursing education[.]: and

(2) Approved by the board and the board shall consult, where possible, with nationally recognized accrediting agencies when approving schools.

(c) [The board shall keep] The Department shall post a list of all nursing programs and all programs for training licensed practical nurses that are approved by [it] the board, [with the consent of the Commissioner of Public Health, as maintaining] who maintain the standard for the education of nurses and the training of licensed practical nurses as established by the commissioner on the Department's internet website. [The board shall consult, where possible, with nationally recognized accrediting agencies when approving schools.]

[(b)] (d) Said board shall (1) hear and decide matters concerning suspension or revocation of licensure, (2) adjudicate complaints filed against practitioners licensed under this chapter and impose sanctions where appropriate.

Section 20. Section 19a-16d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Any person or entity, acting on behalf of a health care profession that seeks to establish a new scope of practice or change a profession's scope of practice, may submit a written scope of practice request to the Department of Public Health not later than August fifteenth of the year preceding the commencement of the next regular session of the General Assembly.

(b) (1) Any written scope of practice request submitted to the Department of Public Health pursuant to subsection (a) of this section shall include the following information:

(A) A plain language description of the request;

(B) Public health and safety benefits that the requestor believes will be achieved should the request be implemented and, if applicable, a description of any harm to public health and safety should the request not be implemented;

(C) The impact that the request will have on public access to health care;

(D) A brief summary of state or federal laws that govern the health care profession making the request;

(E) The state's current regulatory oversight of the health care profession making the request;

(F) All current education, training and examination requirements and any relevant certification requirements applicable to the health care profession making the request;

(G) A summary of known scope of practice changes either requested or enacted concerning the health care profession in the five-year period preceding the date of the request;

(H) The extent to which the request directly impacts existing relationships within the health care delivery system;

(I) The anticipated economic impact of the request on the health care delivery system;

(J) Regional and national trends concerning licensure of the health care profession making the request and a summary of relevant scope of practice provisions enacted in other states;

(K) Identification of any health care professions that can reasonably be anticipated to be directly impacted by the request, the nature of the impact and efforts made by the requestor to discuss the request with such health care professions; and

(L) A description of how the request relates to the health care profession's ability to practice to the full extent of the profession's education and training.

(2) In lieu of submitting a scope of practice request as described in subdivision (1) of this subsection, any person or entity acting on behalf of a health care profession may submit a request for an exemption from the processes described in this section and section 19a-16e. A request for exemption shall include a plain language description of the request and the reasons for the request for exemption, including, but not limited to: (A) Exigent circumstances which necessitate an immediate response to the scope of practice request, (B) the lack of any dispute concerning the scope of practice request, or (C) any outstanding issues among health care professions concerning the scope of practice request can easily be resolved. Such request for exemption shall be submitted to the Department of Public Health not later than August fifteenth of the year preceding the commencement of the next regular session of the General Assembly.

(c) In any year in which a scope of practice request is received pursuant to this section, not later than September [fifteenth] first of the year preceding the commencement of the next regular session of the General Assembly, the Department of Public Health, within available appropriations, shall: (1) Provide

written notification to the joint standing committee of the General Assembly having cognizance of matters relating to public health of any health care profession that has submitted a scope of practice request, including any request for exemption, to the department pursuant to this section; and (2) post any such request, including any request for exemption, and the name and address of the requestor on the department's web site.

(d) Any person or entity, acting on behalf of a health care profession that may be directly impacted by a scope of practice request submitted pursuant to this section, may submit to the department a written statement identifying the nature of the impact not later than [October first] September fifteenth of the year preceding the next regular session of the General Assembly. Any such person or entity directly impacted by a scope of practice request shall indicate the nature of the impact taking into consideration the criteria set forth in subsection (b) of this section and shall provide a copy of the written impact statement to the requestor. Not later than October [fifteenth] first of such year, the requestor shall submit a written response to the department and any person or entity that has provided a written impact statement. The requestor's written response shall include, but not be limited to, a description of areas of agreement and disagreement between the respective health care professions

Section 21. Subsection (a) of section 19a-16e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) On or before [November first] October fifteenth of the year preceding the commencement of the next regular session of the General Assembly, the Commissioner of Public Health shall, within available appropriations allocated to the department, establish and appoint members to a scope of practice review committee for each timely scope of practice request submitted to the department pursuant to section 19a-16d. Committees established pursuant to this section shall consist of the following members: (1) Two members recommended by the requestor to represent the health care profession making the scope of practice request; (2) two members recommended by each person or entity that has submitted a written impact statement pursuant to subsection (d) of section 19a-16d to represent the health care professions directly impacted by the scope of practice request; and (3) the Commissioner of Public Health or the commissioner's designee, who shall serve as an ex-officio, nonvoting member of the committee. The Commissioner of Public Health or the commissioner's designee shall serve as the chairperson of any such committee. The Commissioner of Public Health may appoint additional members to any committee established pursuant to this section to include representatives from health care professions having a proximate relationship to the underlying request if the commissioner or the commissioner's designee determines that such expansion would be beneficial to a resolution of the issues presented. Any member of such committee shall serve without compensation.

Section 22. Section 20-132a of the general statutes is repealed and the following is substituted in lieu thereof: (*Effective from passage*):

(a) For purposes of this section, "actively engaged in the practice of optometry" means the treatment of one or more patients by a licensee during any given registration period, and "registration period" means the twelve-month period for which a license has been renewed in accordance with section 19a-88.

(b) Licenses issued under this chapter shall be renewed annually in accordance with the provisions of section 19a-88.

(c) Except as provided in this section, a licensee who is actively engaged in the practice of optometry shall earn a minimum of twenty hours of continuing education each registration period. The subject matter for continuing education shall reflect the professional needs of the licensee in order to meet the health care needs of the public, and shall include (1) not less than six hours in any of the following areas: Pathology, detection of diabetes and ocular treatment; and (2) not less than six hours in treatment as it applies to the use of ocular agents-T.

(d) Coursework shall be provided in the following manner:

(1) Not less than ten hours shall be provided through direct, live instruction that the licensee physically attends [either individually or as part of a group of participants or through a formal home study or distance learning program.]; and

(2) Not more than ten hours shall be obtained online through real time synchronous education with opportunities for live interaction;

(3) Not more than [six] five hours shall be earned through a nonsynchronous home study or other distance learning program; [and] or

(4) [not] Not more than six hours shall be in practice management.

(e) Qualifying continuing education activities include, but are not limited to, courses offered or approved by the Council on Optometric Practitioner Education of the Association of Regulatory Boards of Optometry, the American Optometric Association or state or local optometry associations and societies that are affiliated with the American Optometric Association, a hospital or other health care institution, a school or college of optometry or other institution of higher education accredited or recognized by the Council on Optometric Practitioner Education or the American Optometric Association, a state or local health department, or a national, state or local medical association.

[(d)] (f) Each licensee applying for license renewal pursuant to section 19a-88, except a licensee applying for a license renewal for the first time, shall sign a statement attesting that he or she has satisfied the continuing education requirements described in subsection (c) of this section on a form prescribed by the Department of Public Health. Each licensee shall retain records of attendance or certificates of completion that demonstrate compliance with the continuing education requirements described in subsection (c) of this section for not less than three years following the date on which the continuing education was completed or the license was renewed. Each licensee shall submit such records to the department for inspection not later than forty-five days after a request by the department for such records. A licensee who fails to comply with the provisions of this subsection may be subject to disciplinary action pursuant to section 20-133.

[(e)] (g) In individual cases involving medical disability or illness, the Commissioner of Public Health may grant a waiver of the continuing education requirements or an extension of time within which to fulfill the requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the commissioner, along with a certification by a licensed physician or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

[(f)] (h) A licensee who is not actively engaged in the practice of optometry, in any form, during a registration period shall be exempt from the continuing education requirements, provided the licensee submits a notarized application for exemption on a form prescribed by the commissioner before the end of the registration period. A licensee who is exempt under the provisions of this subsection may not engage in the practice of optometry until the licensee has met the continuing education requirements of this section.

[(g)] (i) A licensee whose license has become void pursuant to section 19a-88 and who applies to the department for reinstatement of such license shall submit evidence of successful completion of twenty contact hours of continuing education within the one-year period immediately preceding the application for reinstatement.

Section 23. Section 19a-14c, as amended by subsection (b) of section 10 of Public Act 21-46, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) A psychiatrist licensed pursuant to chapter 370, a psychologist licensed pursuant to chapter 383, [an independent social worker certified] a clinical social worker licensed pursuant to chapter 383b or a

marital and family therapist licensed pursuant to chapter 383a may provide outpatient mental health treatment to a minor without the consent or notification of a parent or guardian at the request of the minor if (1) requiring the consent or notification of a parent or guardian would cause the minor to reject such treatment; (2) the provision of such treatment is clinically indicated; (3) the failure to provide such treatment would be seriously detrimental to the minor's well-being; (4) the minor has knowingly and voluntarily sought such treatment; and (5) in the opinion of the provider of treatment, the minor is mature enough to participate in treatment productively. The provider of such treatment shall document the reasons for any determination made to treat a minor without the consent or notification of a parent or guardian and shall include such documentation in the minor's clinical record, along with a written statement signed by the minor stating that (A) the minor is voluntarily seeking such treatment; (B) the minor has discussed with the provider the possibility of involving his or her parent or guardian in the decision to pursue such treatment; (C) the minor has determined it is not in his or her best interest to involve his or her parent or guardian in such decision; and (D) the minor has been given adequate opportunity to ask the provider questions about the course of his or her treatment.

Section 24. Subsection (b) section 93 of Public Act 21-121 is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) Each person holding a license as a physician assistant shall, annually, during the month of such person's birth, [register] renew with the Department of Public Health, upon payment of a fee of one hundred fifty dollars, on [blanks] forms to be [furnished] provided by the department for such purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests. No such license shall be renewed unless the department is satisfied that the practitioner (1) has met the mandatory continuing medical education requirements of the National Commission on Certification of Physician Assistants or a successor organization for the certification or recertification of physician assistants that may be approved by the department; (2) has passed any examination or continued competency assessment the passage of which may be required by said commission for maintenance of current certification by said commission; (3) has completed not less than one contact hour of training or education in prescribing controlled substances and pain management in the preceding two-year period; and (4) for registration periods beginning on or [before] after January 1, 2022, during the first renewal period and not less than once every six years thereafter, earn not less than two contact hours of training or education on screening for posttraumatic stress disorder, risk of suicide, depression and grief and suicide prevention training administered by the American [Association] Academy of Physician Assistants, or successor organization, a hospital or other licensed health care institution or a regionally accredited institution of higher education.

Section 25. Subdivision (8) of section 19a-177 of the general statutes is repealed and the following is

substituted in lieu thereof (*Effective from passage*):

(8) (A) Develop an emergency medical services data collection system. Each emergency medical service organization licensed or certified pursuant to this chapter shall submit data to the commissioner, on a quarterly basis, from each licensed ambulance service, certified ambulance service or paramedic intercept service that provides emergency medical services. Such submitted data shall include, but not be limited to: (i) The total number of calls for emergency medical services received by such licensed ambulance service, certified ambulance service or paramedic intercept service through the 9-1-1 system during the reporting period; (ii) each level of emergency medical services, as defined in regulations adopted pursuant to section 19a-179, required for each such call; (iii) the response time for each licensed ambulance service, certified ambulance service or paramedic intercept service during the reporting period; (iv) the number of passed calls, cancelled calls and mutual aid calls, both made and received, during the reporting period; and (v) for the reporting period, the prehospital data for the nonscheduled transport of patients required by regulations adopted pursuant to subdivision (6) of this section. The data required under this subdivision may be submitted in any electronic form selected by such licensed ambulance service, certified ambulance service or paramedic intercept service and approved by the commissioner, provided the commissioner shall take into consideration the needs of such licensed ambulance service, certified ambulance service or paramedic intercept service in approving such electronic form. The commissioner may conduct an audit of any such licensed ambulance service, certified ambulance service or paramedic intercept service as the commissioner deems necessary in order to verify the accuracy of such reported data.

(B) On or before [December 31, 2018] April 1, 2023, and annually thereafter, the commissioner shall prepare a report to the Emergency Medical Services Advisory Board, established pursuant to section 19a-178a, that shall include, but not be limited to, the following data: (i) The total number of calls for emergency medical services received during the reporting year by each licensed ambulance service, certified ambulance service or paramedic intercept service; (ii) the level of emergency medical services required for each such call; (iii) the name of the emergency medical service organization that provided each such level of emergency medical services furnished during the reporting year; (iv) the response time, by time ranges or fractile response times, for each licensed ambulance service, certified ambulance service or paramedic intercept service, using a common definition of response time, as provided in regulations adopted pursuant to section 19a-179; and (v) the number of passed calls, cancelled calls and mutual aid calls during the reporting year. The commissioner shall prepare such report in a format that categorizes such data for each municipality in which the emergency medical services were provided, with each such municipality grouped according to urban, suburban and rural classifications.

(C) If any licensed ambulance service, certified ambulance service or paramedic intercept service does not submit the data required under subparagraph (A) of this subdivision for a period of six consecutive months, or if the commissioner believes that such licensed ambulance service, certified ambulance

service or paramedic intercept service knowingly or intentionally submitted incomplete or false data, the commissioner shall issue a written order directing such licensed ambulance service, certified ambulance service or paramedic intercept service to comply with the provisions of subparagraph (A) of this subdivision and submit all missing data or such corrected data as the commissioner may require. If such licensed ambulance service, certified ambulance service or paramedic intercept service fails to fully comply with such order not later than three months from the date such order is issued, the commissioner (i) shall conduct a hearing, in accordance with chapter 54, at which such licensed ambulance service, certified ambulance service or paramedic intercept service shall be required to show cause why the primary service area assignment of such licensed ambulance service, certified ambulance service or paramedic intercept service should not be revoked, and (ii) may take such disciplinary action under section 19a-17 as the commissioner deems appropriate.

(D) The commissioner shall collect the data required by subparagraph (A) of this subdivision, in the manner provided in said subparagraph, from each emergency medical service organization licensed or certified pursuant to this chapter. Any such emergency medical service organization that fails to comply with the provisions of this section shall be liable for a civil penalty not to exceed one hundred dollars per day for each failure to report the required data regarding emergency medical services provided to a patient, as determined by the commissioner. The civil penalties set forth in this subparagraph shall be assessed only after the department provides a written notice of deficiency and the organization is afforded the opportunity to respond to such notice. An organization shall have not more than fifteen business days after the date of receiving such notice to provide a written response to the department. The commissioner may adopt regulations, in accordance with chapter 54, concerning the development, implementation, monitoring and collection of emergency medical service system data. All state agencies licensed or certified as emergency medical service organizations shall be exempt from the civil penalties set forth in this subparagraph.

(E) The commissioner shall, with the recommendation of the Connecticut Emergency Medical Services Advisory Board established pursuant to section 19a-178a, adopt for use in trauma data collection the most recent version of the National Trauma Data Bank's National Trauma Data Standards and Data Dictionary and nationally recognized guidelines for field triage of injured patients;

Section 26. Subdivision (5) of section 14-1 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(5) "Authorized emergency vehicle" means (A) a fire department vehicle, (B) a police vehicle, or (C) [an ambulance] or authorized emergency medical services vehicle;

Section 27. (NEW) (Formerly section 19a-30 of the general statutes, as amended by Public Act 21-121) (*Effective from passage*):

(a) As used in this section, "clinical laboratory" as defined in section 19a-490.

(b) The Department of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, to establish reasonable standards governing exemptions from the licensing provisions of this section, clinical laboratory operations and facilities, personnel qualifications and certification, levels of acceptable proficiency in testing programs approved by the department, the collection, acceptance and suitability of specimens for analysis and such other pertinent laboratory functions, including the establishment of advisory committees, as may be necessary to insure public health and safety. No person, firm or corporation shall establish, conduct, operate or maintain a clinical laboratory unless such laboratory is licensed or approved by said department in accordance with its regulations. Each clinical laboratory shall comply with all standards for clinical laboratories established by the department and shall be subject to inspection by said department, including inspection of all records necessary to carry out the purposes of this section. The commissioner, or an agent authorized by the commissioner, may conduct any inquiry, investigation or hearing necessary to enforce the provisions of this section or regulations adopted under this section and shall have power to issue subpoenas, order the production of books, records or documents, administer oaths and take testimony under oath relative to the matter of such inquiry, investigation or hearing. At any such hearing ordered by the department, the commissioner or such agent may subpoena witnesses and require the production of records, papers and documents pertinent to such hearing. If any person disobeys such subpoena or, having appeared in obedience thereto, refuses to answer any pertinent question put to such person by the commissioner or such agent or to produce any records and papers pursuant to the subpoena, the commissioner or such agent may apply to the superior court for the judicial district of Hartford or for the judicial district wherein the person resides or wherein the business has been conducted, setting forth such disobedience or refusal and said court shall cite such person to appear before said court to answer such question or to produce such records and papers.

(c) Each application for licensure of a clinical laboratory, if such laboratory is located within an institution licensed in accordance with sections 19a-490 to 19a-503, inclusive, shall be made on forms provided by said department and shall be executed by the owner or owners or by a responsible officer of the firm or corporation owning the laboratory. Such application shall contain a current itemized rate schedule, full disclosure of any contractual relationship, written or oral, with any practitioner using the services of the laboratory and such other information as said department requires, which may include affirmative evidence of ability to comply with the standards as well as a sworn agreement to abide by them. Upon receipt of any such application, said department shall make such inspections and investigations as are necessary and shall deny licensure when operation of the clinical laboratory would be prejudicial to the health of the public. Licensure shall not be in force until notice of its effective date and term has been sent to the applicant.

(d) A nonrefundable fee of two hundred dollars shall accompany each application for a license or for renewal thereof, except in the case of a clinical laboratory owned and operated by a municipality, the state, the United States or any agency of said municipality, state or United States. Each license shall be issued for a period of not less than twenty-four nor more than twenty-seven months from the deadline for applications established by the commissioner. Renewal applications shall be made (1) biennially within the twenty-fourth month of the current license; (2) before any change in ownership or change in director is made; and (3) prior to any major expansion or alteration in quarters. The licensed clinical laboratory shall report to the Department of Public Health, in a form and manner prescribed by the commissioner, the name and address of each blood collection facility owned and operated by the clinical laboratory, prior to the issuance of a new license, prior to the issuance of a renewal license or whenever a blood collection facility opens or closes.

(e) A license issued under this section may be revoked or suspended in accordance with chapter 54 or subject to any other disciplinary action specified in section 19a-17 if such laboratory has engaged in fraudulent practices, fee-splitting inducements or bribes, including but not limited to violations of subsection (f) of this section, or violated any other provision of this section or regulations adopted under this section after notice and a hearing is provided in accordance with the provisions of said chapter.

(f) No representative or agent of a clinical laboratory shall solicit referral of specimens to his or any other clinical laboratory in a manner which offers or implies an offer of fee-splitting inducements to persons submitting or referring specimens, including inducements through rebates, fee schedules, billing methods, personal solicitation or payment to the practitioner for consultation or assistance or for scientific, clerical or janitorial services.

(g) No clinical laboratory shall terminate the employment of an employee because such employee reported a violation of this section to the Department of Public Health.

(h) Any person, firm or corporation operating a clinical laboratory in violation of this section shall be fined not less than one hundred dollars or more than three hundred dollars for each offense. For purposes of calculating civil penalties under this section, each day a licensee operates in violation of this section, or a regulation adopted under this section shall constitute a separate violation.

(i) The Commissioner of Public Health shall adopt regulations in accordance with the provisions of chapter 54 to establish levels of acceptable proficiency to be demonstrated in testing programs approved by the department for those laboratory tests which are not performed in a licensed clinical laboratory. Such levels of acceptable proficiency shall be determined on the basis of the volume, or the complexity of the examinations performed.

Section 28. (NEW) (Formerly Sec. 19a-30a. Reporting of clinical laboratory errors.) (*Effective from passage*):

(a) Each clinical laboratory, licensed pursuant to section 19a-490, which discovers a medical error made in the performance or reporting of any test or examination performed by the laboratory shall promptly notify, in writing, the authorized person ordering the test of the existence of such error and shall promptly issue a corrected report or request for a retest, with the exception of HIV testing, in which case, errors shall be reported in person and counseling provided in accordance with chapter 368x.

(b) If the patient has requested the test directly from the laboratory, notice shall be sent to the patient, in writing, stating that a medical error in the reported patient test results has been detected and the patient is requested to contact the laboratory to arrange for a retest or other confirmation of test results. Said laboratory shall verbally or in writing inform the patient that in the event of a medical error the laboratory is required by law to inform him and that he may designate where such notification is to be sent. Such written notification shall be confidential and subject to the provisions of chapter 368x.
(c) Failure to comply with the provisions of this section may be cause for suspension or revocation of the license granted under said section 27 of this act or the imposition of any other disciplinary action specified in section 19a-17.

(d) The Department of Public Health may adopt regulations in accordance with the provisions of chapter 54 to implement the provisions of this section.

Section 29. (NEW) (Formerly Section 19a-31) (*Effective from passage*):

Any licensed clinical laboratory in this state shall accept or obtain specimens for analysis at the request of any chiropractic physician licensed under the provisions of chapter 372.

Section 30. (NEW) (Formerly Section 19a-31b of the general statutes) (*Effective from passage*):

No clinical laboratory, as defined in section 19a-490, that offers hair follicle drug testing as part of its array of diagnostic testing services shall refuse to administer a hair follicle drug test that has been ordered by a physician or physician assistant, licensed pursuant to chapter 370, or an advanced practice registered nurse, licensed pursuant to chapter 378.

Section 31. Subsection (b) of section 17b-59e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) Not later than one year after commencement of the operation of the State-wide Health Information Exchange, each hospital and clinical laboratory licensed under chapter 368v [and clinical laboratory licensed under section 19a-30] shall maintain an electronic health record system capable of connecting to and participating in the State-wide Health Information Exchange and shall apply to begin the process of connecting to, and participating in, the State-wide Health Information Exchange.

Section 32. Subsection (a) of section 19a-72 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section:

(1) "Clinical laboratory" [means any facility or other area used for microbiological, serological, chemical, hematological, immunohematological, biophysical, cytological, pathological or other examinations of human body fluids, secretions, excretions or excised or exfoliated tissues, for the purpose of providing information for the diagnosis, prevention or treatment of any human disease or impairment, for the assessment of human health or for the presence of drugs, poisons or other toxicological substances] has the same meaning as provided in section 19a-490;

(2) "Hospital" [means an establishment for the lodging, care and treatment of persons suffering from disease or other abnormal physical or mental conditions and includes inpatient psychiatric services in general hospitals] has the same meaning as provided in section 19a-490;

(3) "Health care provider" means any person or organization that furnishes health care services and is licensed or certified to furnish such services pursuant to chapters 370, 372, 373, 375, 378 and 379 or is licensed or certified pursuant to chapter 384d;

(4) "Occupation" means the usual kind of work performed by an individual;

(5) "Industry" means the type of business to which an occupation relates; and

(6) "Reportable tumor" means tumors and conditions included in the Connecticut Tumor Registry reportable list maintained by the Department of Public Health, as amended from time to time, as deemed necessary by the department.

Section 33. Section 19a-110 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Not later than forty-eight hours after receiving or completing a report of a person found to have a level of lead in the blood equal to or greater than ten micrograms per deciliter of blood or any other abnormal body burden of lead, each institution or clinical laboratory licensed under sections 19a-490 to 19a-503, inclusive, [and each clinical laboratory licensed under section 19a-30] shall report to (1) the Commissioner of Public Health, and to the director of health of the town, city, borough or district in which the person resides: (A) The name, full residence address, date of birth, gender, race and ethnicity of each person found to have a level of lead in the blood equal to or greater than ten micrograms per deciliter of blood or any other abnormal body burden of lead; (B) the name, address and telephone number of the health care provider who ordered the test; (C) the sample collection date, analysis date, type and blood lead analysis result; and (D) such other information as the commissioner may require, and (2) the health care provider who ordered the test, the results of the test. With respect to a child under three years of age, not later than seventy-two hours after the provider receives such results, the provider shall make reasonable efforts to notify the parent or guardian of the child of the blood lead analysis results. Any institution or laboratory making an accurate report in good faith shall not be liable for the act of disclosing said report to the Commissioner of Public Health or to the director of health. The commissioner, after consultation with the Commissioner of Administrative Services, shall determine the method and format of transmission of data contained in said report.

Section 34. Subsection (a) of section 19a-215 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) For the purposes of this section:

(1) "Clinical laboratory" [means any facility or other area used for microbiological, serological, chemical, hematological, immunohematological, biophysical, cytological, pathological or other examinations of human body fluids, secretions, excretions or excised or exfoliated tissues, for the purpose of providing information for the diagnosis, prevention or treatment of any human disease or impairment, for the assessment of human health or for the presence of drugs, poisons or other toxicological substances] has the same meaning as provided in section 19a-490.

(2) "Commissioner's list of reportable diseases, emergency illnesses and health conditions" and "commissioner's list of reportable laboratory findings" means the lists developed pursuant to section 19a-2a.

(3) "Confidential" means confidentiality of information pursuant to section 19a-25.

(4) “Health care provider” means a person who has direct or supervisory responsibility for the delivery of health care or medical services, including licensed physicians, nurse practitioners, nurse midwives, physician assistants, nurses, dentists, medical examiners and administrators, superintendents and managers of health care facilities.

(5) “Reportable diseases, emergency illnesses and health conditions” means the diseases, illnesses, conditions or syndromes designated by the Commissioner of Public Health on the list required pursuant to section 19a-2a.

Section 35. Subsection (a) of section 19a-269b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section, “clinical laboratory” has the same meaning as provided in section [19a-30] 19a-490.

Section 36. Subsection (b) of section 19a-415a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) Upon receiving the written consent of a deceased person's next of kin, the Office of the Chief Medical Examiner shall release biologic material of the deceased person to a clinical laboratory, licensed in accordance with the provisions of section [19a-30] 27 of this act, for the purpose of determining paternity or for the purpose of determining a diagnosis of a life-threatening illness in a living individual.

Section 37. Subsection (d) of section 20-7a. of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) No person or entity, other than a physician licensed under chapter 370, a clinical laboratory, as defined in section [19a-30] 19a-490, or a referring clinical laboratory, shall directly or indirectly charge, bill or otherwise solicit payment for the provision of anatomic pathology services, unless such services were personally rendered by or under the direct supervision of such physician, clinical laboratory or referring laboratory in accordance with section 353 of the Public Health Service Act, (42 USC 263a). A clinical laboratory or referring laboratory may only solicit payment for anatomic pathology services from the patient, a hospital, the responsible insurer of a third party payor, or a governmental agency or such agency's public or private agent that is acting on behalf of the recipient of such services. Nothing in this subsection shall be construed to prohibit a clinical laboratory from billing a referring clinical

laboratory when specimens are transferred between such laboratories for histologic or cytologic processing or consultation. No patient or other third party payor, as described in this subsection, shall be required to reimburse any provider for charges or claims submitted in violation of this section. For purposes of this subsection, (1) "referring clinical laboratory" means a clinical laboratory that refers a patient specimen for consultation or anatomic pathology services, excluding the laboratory of a physician's office or group practice that takes a patient specimen and does not perform the professional diagnostic component of the anatomic pathology services involved, and (2) "anatomic pathology services" means the gross and microscopic examination and histologic or cytologic processing of human specimens, including histopathology or surgical pathology, cytopathology, hematology, subcellular pathology or molecular pathology or blood banking service performed by a pathologist.

Section 38. Subsection (a) of section 20-7c of the general statutes are repealed and the following is substitution in lieu thereof (*Effective from passage*):

(a) For purposes of this section, "clinical laboratory" has the same meaning as provided in section [19a-30] 19a-490. "Clinical laboratory" does not include any state laboratory established by the Department of Public Health pursuant to section 19a-26 or 19a-29.

Section 39. Section 38a-477aa is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section:

(1) "Emergency condition" has the same meaning as "emergency medical condition", as provided in section 38a-591a;

(2) "Emergency services" means, with respect to an emergency condition, (A) a medical screening examination as required under Section 1867 of the Social Security Act, as amended from time to time, that is within the capability of a hospital emergency department, including ancillary services routinely available to such department to evaluate such condition, and (B) such further medical examinations and treatment required under said Section 1867 to stabilize such individual, that are within the capability of the hospital staff and facilities;

(3) “Health care plan” means an individual or a group health insurance policy or health benefit plan that provides coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469;

(4) “Health care provider” means an individual licensed to provide health care services under chapters 370 to 373, inclusive, chapters 375 to 383b, inclusive, and chapters 384a to 384c, inclusive;

(5) “Health carrier” means an insurance company, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that delivers, issues for delivery, renews, amends or continues a health care plan in this state;

(6) (A) “Surprise bill” means a bill for health care services, other than emergency services, received by an insured for services rendered by an out-of-network health care provider, where such services were rendered by (i) such out-of-network provider at an in-network facility, during a service or procedure performed by an in-network provider or during a service or procedure previously approved or authorized by the health carrier and the insured did not knowingly elect to obtain such services from such out-of-network provider, or (ii) a clinical laboratory, as defined in section [19a-30] 19a-490, that is an out-of-network provider, upon the referral of an in-network provider.

(B) “Surprise bill” does not include a bill for health care services received by an insured when an in-network health care provider was available to render such services and the insured knowingly elected to obtain such services from another health care provider who was out-of-network.

Section 40. Section 38a-479aa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this part and subsection (b) of section 20-138b:

(1) “Covered benefits” means health care services to which an enrollee is entitled under the terms of a managed care plan;

(2) “Enrollee” means an individual who is eligible to receive health care services through a preferred provider network;

(3) “Health care services” means health care related services or products rendered or sold by a provider within the scope of the provider's license or legal authorization, and includes hospital, medical, surgical, dental, vision and pharmaceutical services or products;

(4) “Managed care organization” means (A) a managed care organization, as defined in section 38a-478, (B) any other health insurer, or (C) a reinsurer with respect to health insurance;

(5) “Managed care plan” has the same meaning as provided in section 38a-478;

(6) “Person” means an individual, agency, political subdivision, partnership, corporation, limited liability company, association or any other entity;

(7) “Preferred provider network” means a person that is not a managed care organization, but that pays claims for the delivery of health care services, accepts financial risk for the delivery of health care services and establishes, operates or maintains an arrangement or contract with providers relating to (A) the health care services rendered by the providers, and (B) the amounts to be paid to the providers for such services. “Preferred provider network” does not include (i) a workers' compensation preferred provider organization established pursuant to section 31-279-10 of the regulations of Connecticut state agencies, (ii) an independent practice association or physician hospital organization whose primary function is to contract with insurers and provide services to providers, (iii) a clinical laboratory, licensed pursuant to section [19a-30] 19a-490, whose primary payments for any contracted or referred services are made to other licensed clinical laboratories or for associated pathology services, or (iv) a pharmacy benefits manager responsible for administering pharmacy claims whose primary function is to administer the pharmacy benefit on behalf of a health benefit plan;

(8) “Provider” means an individual or entity duly licensed or legally authorized to provide health care services; and

(9) “Commissioner” means the Insurance Commissioner.

Section 41. Subsection (b) of section 51-164n of the general statutes, as amended by section 6 of Public Act 21-1, section 305 of Public Act 21-2, section 18 of Public Act 21-37, section 2 of Public Act 21-89, section 58 of Public Act 21-104, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) Notwithstanding any provision of the general statutes, any person who is alleged to have committed (1) a violation under the provisions of section 1-9, 1-10, 1-11, 4b-13, 7-13, 7-14, 7-35, 7-41, 7-83, 7-283, 7-325, 7- 393, 8-12, 8-25, 8-27, 9-63, 9-322, 9-350, 10-193, 10-197, 10-198, 10-230, 10- 251, 10-254, 12-52, 12-170aa, 12-292, 12-314b or 12-326g, subdivision (4) of section 12-408, subdivision (3), (5) or (6) of section 12-411, section 12- 435c, 12-476a, 12-476b, 12-487, 13a-71, 13a-107, 13a-113, 13a-114, 13a-115, 13a-117b, 13a-123, 13a-124, 13a-139, 13a-140, 13a-143b, 13a-247 or 13a253, subsection (f) of section 13b-42, section 13b-90, 13b-221, 13b-292, 13b-336, 13b-337, 13b-338, 13b-410a, 13b-410b or 13b-410c, subsection (a), (b) or (c) of section 13b-412, section 13b-414, subsection (d) of section 14-

12, section 14-20a or 14-27a, subsection (f) of section 14-34a, subsection (d) of section 14-35, section 14-43, 14-49, 14-50a or 14-58, subsection (b) of section 14-66, section 14-66a or 14-67a, subsection (g) of section 14-80, subsection (f) of section 14-80h, section 14-97a, 14-100b, 14-103a, 14-106a, 14-106c, 14-146, 14-152, 14-153 or 14-163b, a first violation as specified in subsection (f) of section 14-164i, section 14-219 as specified in subsection (e) of said section, subdivision (1) of section 14-223a, section 14-240, 14-250 or 14-253a, subsection (a) of section 14- 261a, section 14-262, 14-264, 14-267a, 14-269, 14-270, 14-275a, 14-278 or 14-279, subsection (e) or (h) of section 14-283, section 14-291, 14-293b, 14- 296aa, 14-300, 14-300d, 14-319, 14-320, 14-321, 14-325a, 14-326, 14-330 or 14-332a, subdivision (1), (2) or (3) of section 14-386a, section 15-25 or 15- 33, subdivision (1) of section 15-97, subsection (a) of section 15-115, section 16-44, 16-256e, 16a-15 or 16a-22, subsection (a) or (b) of section 16a-22h, section 17a-24, 17a-145, 17a-149, 17a-152, 17a-465, 17b-124, 17b131, 17b-137, [19a-30] section 27 of this act, 19a-33, 19a-39 or 19a-87, subsection (b) of section 19a-87a, section 19a-91, 19a-105, 19a-107, 19a-113, 19a-215, 19a-219, 19a222, 19a-224, 19a-286, 19a-287, 19a-297, 19a-301, 19a-309, 19a-335, 19a- 336, 19a-338, 19a-339, 19a-340, 19a-425, Section 41 of this act, 19a-502, 20-7a, 20-14, 20-158, 20- 231, 20-249, 20-257, 20-265, 20-324e, subsection (b) of section 20-334, section 20-341l, 20-366, 20-597, 20-608, 20-610, 21-1, 21-38, 21-39, 21-43, 21-47, 21-48, 21-63, subsection (d) of section 21-71, or section 21-76a, subsection (c) of section 21a-2, subdivision (1) of section 21a-19, section 21a-21, subdivision (1) of subsection (b) of section 21a-25, section 21a-26 or 21a-30, subsection (a) of section 21a-37, section 21a-46, 21a-61, 21a-63 or 21a-77, subsection (b) of section 21a-79, section 21a-85 or 21a-154, subdivision (1) of subsection (a) of section 21a-159, subsection (a) of section 21a-279a, section 22-12b, 22-13, 22-14, 22-15, 22-16, 22-26g, 22-29, 22-30, 22-34, 22-35, 22-36, 22-38, 22-39, 22-39f, 22-49, 22-54, 22-61j, 22-61*l,* subsection (f) of section 22-61m, subsection (d) of section 22-84, section 22-89, 22-90, 22-96, 22- 98, 22-99, 22-100, 22-111o, 22-167, subsection (c) of section 22-277, section 278, 22-279, 22-280a, 22-318a, 22-320h, 22- 324a, 22-326 subsection (b), subdivision (1) or (2) of subsection (e) or subsection (g) of section 22-344, subdivision (2) of subsection (b) of section 22-344b, subsection (d) of section 22-344c, subsection (d) of section 22-344d, section 22-344f, 22-350a, 22-354, 22-359, 22-366, 22-391, 22-413, 22-414, 22-415, 22a-66a or 22a-246, subsection (a) of section 22a-250, subsection (e) of section 22a-256h, section 22a-363 or 22a-381d, subsections (c) and (d) of section 22a-381e, section 22a-449, 22a-461, 23-38, 23-46 or 23-61b, subsection (a) or subdivision (1) of subsection (c) of section 23-65, section 25-37 or 25-40, subsection (a) of section 25-43, section 25-43d, 25-135, 26-18, 26-19, 26- 21, 26-31, 26-40, 26-40a, 26-42, 26-49, 26-54, 26-55, 26-56, 26-58 or 26-59, subdivision (1) of subsection (d) of section 26-61, section 26-64, subdivision (1) of section 26-76, section 26-79, 26-87, 26-89, 26-91, 26-94, 26-97, 26-98, 26-104, 26-105, 26-107, 26-117, 26-128, 26-131, 26-132, 26-138 or 26-141, subdivision (1) of section 26-186, section 26-207, 26-215, 26- 217 or 26-224a, subdivision (1) of section 26-226, section 26-227, 26-230, 26-232, 26-244, 26-257a, 26-260, 26-276, 26-284, 26-285, 26-286, 26-288, 26- 294, 28-13, 29-6a, 29-25, 29-143o, 29-143z or 29-156a, subsection (b), (d), (e) or (g) of section 29-161q, section 29-161y or 29-161z, subdivision (1) of section 29-198, section 29-210, 29-243 or 29-277, subsection (c) of section 29-291c, section 29-316, 29-318, 29-381, 30-48a, 30-86a, 31-3, 31- 10, 31-11, 31-12, 31-13, 31-14, 31-15, 31-16, 31-18, 31-23, 31-24, 31-25, 31- 32, 31-36, 31-38, 31-40, 31-44, 31-47, 31-48, 31-51, 31-52,

31-52a or 31-54, subsection (a) or (c) of section 31-69, section 31-70, 31-74, 31-75, 31-76, 31-76a, 31-89b or 31-134, subsection (i) of section 31-273, section 31-288, subdivision (1) of section 35-20, section 36a-787, 42-230, 45a-283, 45a450, 45a-634 or 45a-658, subdivision (13) or (14) of section 46a-54, section 46a-59, 46b-22, 46b-24, 46b-34, 47-34a, 47-47, 49-8a, 49-16, 53-133, 53-199, 53-212a, 53-249a, 53-252, 53-264, 53-280, 53-302a, 53-303e, 53-311a, 53- 321, 53-322, 53-323, 53-331 or 53-344, subsection (c) of section 53-344b, or section 53-450, or (2) a violation under the provisions of chapter 268, or (3) a violation of any regulation adopted in accordance with the provisions of section 12-484, 12-487 or 13b-410, or (4) a violation of any ordinance, regulation or bylaw of any town, city or borough, except violations of building codes and the health code, for which the penalty exceeds ninety dollars but does not exceed two hundred fifty dollars, unless such town, city or borough has established a payment and hearing procedure for such violation pursuant to section 7-152c, shall follow the procedures set forth in this section.

Section 42. Section 7-51a of the general statutes as amended by section 156 of Public Act 21-2 of the June Special Session is repealed (*Effective from passage*):

(a) Any person eighteen years of age or older may purchase certified copies of marriage and death records, and certified copies of records of births or fetal deaths which are at least one hundred years old, in the custody of any registrar of vital statistics. The department may issue uncertified copies of death certificates for deaths occurring less than one hundred years ago, and uncertified copies of birth, marriage, death and fetal death certificates for births, marriages, deaths and fetal deaths that occurred at least one hundred years ago, to researchers approved by the department pursuant to section 19a-25, and to state and federal agencies approved by the department. During all normal business hours, members of genealogical societies incorporated or authorized by the Secretary of the State to do business or conduct affairs in this state shall (1) have full access to all vital records in the custody of any registrar of vital statistics, including certificates, ledgers, record books, card files, indexes and database printouts, except for those records containing Social Security numbers protected pursuant to 42 USC 405 (c)(2)(C), and confidential files on adoptions, gender change, gestational agreements and paternity, (2) be permitted to make notes from such records, (3) be permitted to purchase certified copies of such records, and (4) be permitted to incorporate statistics derived from such records in the publications of such genealogical societies. For all vital records containing Social Security numbers that are protected from disclosure pursuant to federal law, the Social Security numbers contained on such records shall be redacted from any certified copy of such records issued to a genealogist by a registrar of vital statistics.

(b) For marriage and civil union licenses, the Social Security numbers of the parties to the marriage or civil union shall be recorded in the “administrative purposes” section of the marriage or civil union

license and the application for such license. All persons specified on the license, including the parties to the marriage or civil union, officiator and local registrar shall have access to the Social Security numbers specified on the marriage or civil union license and the application for such license for the purpose of processing the license. Only the parties to a marriage or civil union, or entities authorized by state or federal law, may receive a certified copy of a marriage or civil union license with the Social Security numbers included on the license. Any other individual, researcher or state or federal agency requesting a certified or uncertified copy of any marriage or civil union license in accordance with the provisions of this section shall be provided such copy with such Social Security numbers removed or redacted, or with the "administrative purposes" section omitted.

(c) For deaths occurring on or after July 1, 1997, the Social Security number of the deceased person shall be recorded in the "administrative purposes" section of the death certificate. Such administrative purposes section, and the Social Security number contained therein, shall be restricted and disclosed only to the following eligible parties: (1) All parties specified on the death certificate, including the informant, licensed funeral director, licensed embalmer, conservator, surviving spouse, physician or advanced practice registered nurse and town clerk, for the purpose of processing the certificate, (2) the surviving spouse, (3) the next of kin, or (4) any state and federal agencies authorized by federal law. The department shall provide any other individual, researcher or state or federal agency requesting a certified or uncertified death certificate, or the information contained within such certificate, for a death occurring on or after July 1, 1997, such certificate or information. The decedent's Social Security number shall be removed or redacted from such certificate or information or the administrative purposes section shall be omitted from such certificate.

(d) The registrar of vital statistics of any town or city in this state that has access to an electronic vital records system, as authorized by the department, may use such system to issue certified copies of birth, death, fetal death or marriage certificates that are electronically filed in such system.

[(e) Any registrar of vital statistics who receives payment pursuant to this section may permit such payment to be made on an Internet web site designated by the registrar, in a manner prescribed by the registrar.]

Section 43. Section 7-74 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The fee for a certification of birth registration, short form, shall be fifteen dollars. The fee for a certified copy of a certificate of birth, long form, shall be twenty dollars, except that the fee for such certifications and copies when issued by the department shall be thirty dollars.

(b) (1) The fee for a certified copy of a certificate of marriage or death shall be twenty dollars. Such fees shall not be required of the department.

(2) Any fee received by the Department of Public Health for a certificate of death shall be deposited in the neglected cemetery account, established in accordance with section 19a-308b.

(c) The fee for one certified copy of a certificate of death for any deceased person who was a veteran, as defined in subsection (a) of section 27-103, shall be waived when such copy is requested by a spouse, child or parent of such deceased veteran.

(d) The fee for an uncertified copy of an original certificate of birth issued pursuant to section 7-53 shall be sixty-five dollars.

(e) Any registrar of vital statistics who receives payment pursuant to this section may permit such payment to be made on an Internet web site designated by the registrar, in a manner prescribed by the registrar, as approved by the Commissioner of Public Health, or the commissioner's designee.

Section 44. Subsections (c) and (d) of section 19a-36m of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) The provisions of the food code that concern the employment of a certified food protection manager and any reporting requirements relative to such certified food protection manager [(1)] shall not apply to (A) an owner or operator of a soup kitchen that relies exclusively on services provided by volunteers, (B) any volunteer who serves meals from a nonprofit organization, including a temporary food service establishment and a special event sponsored by a nonprofit civic organization, including, but not limited to, school sporting events, little league food booths, church suppers and fairs, or (C) any person who serves meals to individuals at a registered congregate meal site funded under Title III of the Older Americans Act of 1965, as amended from time to time, that were prepared under the supervision of a certified food protection manager**[**, and (2) shall not prohibit the sale or distribution of food at (A) a bed and breakfast establishment that prepares and offers food to guests, provided the operation is owner-occupied and the total building occupant load is not more than sixteen persons, including the owner and occupants, has no provisions for cooking or warming food in the guest rooms, breakfast is the only meal offered and the consumer of such operation is informed by statements contained in published advertisements, mailed brochures and placards posted in the registration area that the food is prepared in a kitchen that is not regulated and inspected by the local health director, and (B) a noncommercial function, including, but not limited to, an educational, religious, political or charitable organization's bake sale or potluck supper, provided the seller or person distributing the food maintains the food at the temperature, pH level and water activity level conditions that will inhibit the growth of infectious or toxigenic microorganisms. For the purposes of this subsection, "noncommercial function"

means a function where food is sold or distributed by a person not regularly engaged in the business of selling such food for profit**]**.

(d) The provisions of the food code shall not apply to (1) a residential care home with thirty beds or less that is licensed pursuant to chapter 368v, provided the administrator of the residential care home or the administrator's designee has satisfactorily passed a test as part of a food protection manager certification program that is evaluated and approved by an accrediting agency recognized by the Conference for Food Protection as conforming to its standard for accreditation of food protection manager certification programs, unless such residential care home enters into a service contract with a food establishment or lends, rents or leases any area of its facility to any person or entity for the purpose of preparing or selling food, at which time the provisions of the food code shall apply to such residential care home and (2) shall not prohibit the sale or distribution of food at (A) a bed and breakfast establishment that prepares and offers food to guests, provided the operation is owner-occupied and the total building occupant load is not more than sixteen persons, including the owner and occupants, has no provisions for cooking or warming food in the guest rooms, breakfast is the only meal offered and the consumer of such operation is informed by statements contained in published advertisements, mailed brochures and placards posted in the registration area that the food is prepared in a kitchen that is not regulated and inspected by the local health director, and (B) a noncommercial function, including, but not limited to, an educational, religious, political or charitable organization's bake sale or potluck supper, provided the seller or person distributing the food maintains the food at the temperature, pH level and water activity level conditions that will inhibit the growth of infectious or toxigenic microorganisms. For the purposes of this subsection, "noncommercial function" means a function where food is sold or distributed by a person not regularly engaged in the business of selling such food for profit.

Section 45. Section 16-245n(c)(2)(A) of the general statutes as amended by section 19 of Public Act 21-115 is repealed and the following is substituted in lieu thereof *(effective upon passage)*:

(2) (A) There is hereby created an Environmental Infrastructure Fund which shall be within the Connecticut Green Bank. The fund may receive any amount required by law to be deposited into the fund and may receive any federal funds as may become available to the state for environmental infrastructure investments, except that the fund shall not receive: (i) Ratepayer or Regional Greenhouse Gas Initiative funds, (ii) funds that have been deposited in, or are required to be deposited in, an account of the Clean Water Fund pursuant to sections 22a-475 to [22a-438f] 22a-483f, inclusive, or (iii) funds collected from a water company, as defined in section 25-32a.

Section 46. Subsection (b) of section 20-191c is repealed and the following is substituted in lieu thereof (*effective July 1, 2022*)

(b) Qualifying continuing education activities shall be related to the practice of psychology and shall include courses, seminars, workshops, conferences and postdoctoral institutes offered or approved by: (1) The American Psychological Association; (2) a regionally accredited institution of higher education graduate program; (3) a nationally recognized provider of continuing education seminars; (4) the Department of Mental Health and Addiction Services; or (5) a behavioral science organization that is professionally or scientifically recognized. Not more than five continuing education units during each registration period shall be completed via [the Internet] nonsynchronous online, distance learning or home study. Not less than five continuing education units shall be live, synchronous, and interactive. On and after January 1, 2016, qualifying continuing education activities shall include not less than two contact hours of training or education during the first renewal period in which continuing education is required and not less than once every six years thereafter on the topic of mental health conditions common to veterans and family members of veterans, including (A) determining whether a patient is a veteran or family member of a veteran, (B) screening for conditions such as post-traumatic stress disorder, risk of suicide, depression and grief, and (C) suicide prevention training. Qualifying continuing education activities may include a licensee's research-based presentation at a professional conference, provided not more than five continuing education units during each registration period shall be completed by such activities. A licensee who has earned a diploma from the American Board of Professional Psychology during the registration period may substitute the diploma for continuing education requirements for such registration period. For purposes of this section, "continuing education unit" means fifty to sixty minutes of participation in accredited continuing professional education.

Section 47. Section 10 of Public Act 21-185 is repealed and the following is substituted in lieu thereof (effective upon passage):

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

(b) The commissioner shall adopt regulations in accordance with the provisions of chapter 54 of the general statutes that set forth nursing home staffing level requirements to implement the provisions of this section. The Commissioner of Public Health may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulations, provided notice of intent to adopt regulations is published on the eRegulations system not later than twenty days after the date of implementation. Policies and

procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Section 48. Sections 19a-30, 19a-30a, 19a-31 and 19a-31b are repealed.