OLR Bill Analysis

sSB 7 (as amended by House "A" and Senate "A" and "B")*

AN ACT CONCERNING PROTECTIONS FOR ACCESS TO HEALTH CARE AND THE EQUITABLE DELIVERY OF HEALTH CARE SERVICES IN THE STATE.

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SUMMARY

This bill makes changes to laws related to hospital emergency departments, a safe harbor account (with private funds) for reproductive or gender-affirming care, public health funding, and various other health care-related matters, as described in the section-by-section analysis below.

*Senate Amendment "A" removes from the underlying bill provisions that would have (1) placed various limitations on health care entities' ability to discipline providers for actions related to reproductive, gender-affirming, or emergency health care services; (2) required the State Department of Education to create a pilot program in priority school districts on mental and behavioral health awareness and treatment using an online tool; and (3) appropriated money for that pilot program and for the bill's new public health urgent communication and financial safeguard accounts. It also makes various changes to the bill's Emergency Medical Treatment and Labor Act (EMTALA) provisions.

*Senate Amendment "B" replaces the bill as amended by Senate "A." In doing so, it makes various changes to the underlying provisions, such as (1) replacing provisions that generally would have codified EMTALA with a requirement that the Department of Public Health (DPH) adopt regulations implementing EMTALA-related provisions if the federal law gets revoked and (2) reducing the size of the safe harbor account's board and adding certain requirements related to the treasurer's investment of account funds.

It removes provisions that would have created licensure requirements for hospital administrators. It also adds provisions on (1) automated external defibrillators at certain long-term care facilities, (2) a pancreatic cancer screening program, (3) emergency medical services personnel administering glucagon nasal powder, (4) an online hospital financial assistance portal for patients and families, (5) the food code, (6) home health and hospice agencies, (7) an evaluation of health care services for incarcerated individuals, (8) conservator appointments, (9) hospital reporting on emergency departments, (10) a hospital discharge working group, and (11) overdose prevention centers.

*House Amendment "A" removes from the bill (as amended by the Senate) provisions that would have (1) allowed the Department of Mental Health and Addiction Services (DMHAS), in consultation with DPH, to create an overdose prevention center pilot program using private funds and (2) made related changes.

EFFECTIVE DATE: Various; see below.

§ 1 — WATER FLUORIDATION

Codifies the amount of fluoride that water companies must add to the water supply, rather than tying the amount to federal recommendations

The bill codifies the amount of fluoride that water companies must add to the water supply, rather than tying the amount to federal Department of Health and Human Services (HHS) recommendations as current law does. In doing so, it maintains the current required level.

Specifically, it requires water companies to add enough fluoride to maintain an average monthly fluoride content of 0.7 milligrams per liter (mg/L), within a range of 0.15 mg/L greater or lower than this amount. As under current law, the bill applies to water systems that serve at least 20,000 people. (The current HHS recommendation is 0.7 mg/L, but HHS recently directed the Centers for Disease Control and Prevention (CDC) to reexamine the issue.)

EFFECTIVE DATE: Upon passage

Background — Related Bill

SB 1326 (File 288), favorably reported by the Public Health Committee, contains substantially similar provisions on water fluoridation.

§ 2 — FEDERAL RECOMMENDATION ADVISORY COMMITTEE

Allows DPH to create an advisory committee on matters related to CDC and FDA recommendations

The bill expressly allows the Department of Public Health (DPH) commissioner to create a committee to advise her on matters relating to federal CDC and Food and Drug Administration (FDA) recommendations, using evidence-based data from peer-reviewed sources. If convened, the committee must serve in a nonbinding advisory capacity, providing guidance solely at the commissioner's discretion.

The committee may include, among others, the following members from in-state higher education institutions:

1. the deans of public health schools at an independent and a public institution,

2. a primary care physician with at least 10 years of clinical experience and who is a medical school professor,

3. an infectious disease specialist with at least 10 years of clinical experience and who is a professor, and

4. a pediatrician with at least 10 years of clinical experience and expertise in children's health and vaccinations and who is professor.

The committee may also include anyone else the commissioner determines would be beneficial.

EFFECTIVE DATE: Upon passage

§§ 3 & 4 — EMERGENCY DEPARTMENTS AND EMERGENCY CARE PROVIDERS

Requires hospital emergency departments to provide services related to pregnancy complications when necessary; prohibits emergency departments, or their providers, from discriminating on various bases; requires hospitals to comply with the federal EMTALA, and DPH to adopt certain EMTALA-related provisions into state regulations if the federal law is revoked; allows DPH to take disciplinary action against hospitals or providers who violate these provisions

The bill sets various requirements and restrictions for hospital emergency departments related to emergency care and the federal Emergency Medical Treatment and Labor Act (EMTALA, see *Background — EMTALA*).

The bill requires hospital emergency departments, in cases when there is a serious risk to a patient's life or health, to include as part of their required care reproductive health care services related to pregnancy complications if those services are legal in the state and necessary to treat the patient. This at least includes services related to miscarriage management and treating ectopic pregnancies. These provisions generally codify into state law existing requirements under EMTALA.

The bill prohibits emergency departments, or health care providers providing care at them, from discriminating against a patient when providing emergency care based on the person's ethnicity, citizenship, age, preexisting medical condition, insurance or economic status, ability to pay, sex, race, color, religion, disability, genetic information, marital status, sexual orientation, gender identity or expression, primary language, or immigration status. But it is not discrimination for an emergency department provider to consider any of these factors if the provider believes it is medically significant to providing appropriate care.

The bill also requires hospital emergency departments to meet the requirements of (1) EMTALA, including related federal regulations on emergency department patient transfers, capabilities, and on-call professional staff, or (2) any DPH regulations adopted under the bill if EMTALA is revoked, not enforced, or no longer applies (see below).

Under the bill, hospitals that provide emergency care must adopt policies and procedures to implement these provisions and make them available to DPH upon request.

The bill specifies that these provisions do not impact accepted medical standards of care.

EFFECTIVE DATE: Upon passage

Required Regulations If EMTALA Is Revoked (§ 4)

The bill requires the DPH commissioner to adopt regulations to implement certain requirements for hospitals if EMTALA, as it existed as of the bill's passage, in whole or part (1) is revoked, (2) is not being adequately enforced, or (3) no longer applies in Connecticut. The commissioner has the sole discretion to determine whether any of these events occur, but she may consult with the attorney general's office when doing so.

Specifically, the regulations must implement operational requirements for hospitals in Appendix V of the federal Centers for Medicare and Medicaid Services' State Operations Manual for hospitals,

as of December 31, 2024. The appendix includes detailed interpretative guidelines on what hospitals must do to comply with EMTALA.

Under the bill, if the commissioner finds, under existing procedures, that adopting these regulations on fewer than 30 days' notice is needed due to imminent danger to public health, safety, or welfare, she must adopt them (1) without prior notice, public comment period, or hearing or (2) upon any abbreviated notice, public comment period, and hearing, if feasible. Under existing law, the (1) governor must approve a finding that the conditions warrant an emergency regulation and (2) Regulation Review Committee has 15 days to disapprove an emergency regulation (CGS § 4-168(g)).

The bill specifies that it does not (1) require the commissioner to request, or otherwise involve, any federal entity's participation in overseeing or enforcing these regulations or (2) authorize her to adopt these regulations based on routine changes to EMTALA that do not lead to a material loss of patient rights.

Under the bill, if the commissioner adopts these regulations, the Public Health Committee must annually review them and recommend to the commissioner whether she should maintain or repeal them.

Investigations and Disciplinary Action (§ 3(e) & (f))

Under the bill, DPH may investigate each alleged violation of these provisions, unless the commissioner concludes that the (1) facts do not require further investigation or (2) allegation is otherwise without merit.

The bill allows DPH to take disciplinary action, under existing procedures, against hospitals or individual providers. By law, DPH may impose a range of disciplinary actions, such as (1) revoking or suspending a license, (2) issuing a letter of reprimand, (3) placing the institution or person on probationary status, or (4) imposing a civil penalty.

Background — EMTALA

EMTALA requires every hospital with an emergency department that participates in Medicare to screen and treat patients with

emergency medical conditions or arrange for their appropriate transfer if they are unable to do so. They must do this regardless of a person's income, insurance status, or other factors (e.g., immigration status, race, or religion). Hospitals and providers who fail to comply are subject to civil penalties and termination from Medicare or Medicaid (42 U.S.C. § 1395dd and 42 C.F.R. § 1003.500).

Background — Related Bills

sHB 7157 (File 628), § 18, favorably reported by the Public Health Committee, increases the maximum civil penalty that DPH may impose against DPH-credentialed individuals from $10,000 to $25,000.

sSB 1380 (File 736), as amended by Senate "A" and passed by the Senate, prohibits health care providers from knowingly discriminating in providing health care services due to several factors (similar to those under § 3 of this bill).

SB 1481 (File 444), as amended by Senate "A" and passed by the Senate, requires the Commission on Human Rights and Opportunities to report discriminatory health care practices to the Department of Social Services (DSS) and allows DSS to withhold or recoup Medicaid payments from Medicaid-enrolled providers who are found to have discriminated.

§ 5 — SAFE HARBOR ACCOUNT

Creates an account funded by private sources to award grants to nonprofit organizations that provide funding for reproductive or gender-affirming health care services or collateral costs related to these services

The bill creates the "safe harbor account" related to reproductive and gender-affirming health care. The account is a separate, nonlapsing account of the state treasurer administered by a board of trustees, and must contain funds received from private sources (e.g., gifts, grants, or donations) and earnings on those funds. The bill requires the treasurer to follow certain standards when investing the account's funds.

Under the bill, account-related administrative costs (for maintenance or disbursements) must be paid from the account itself and not from taxpayer funds, except the treasurer may use available staff resources to

administer the account.

The board must spend the account's funds to award grants, in line with policies and procedures it adopts, to nonprofits that:

1. provide funding for reproductive or gender-affirming health care services or the collateral costs (such as travel, lodging, or meals, but not the procedure itself) people incur receiving these services in the state; or

2. serve LGBTQ+ youth or families in Connecticut by reimbursing or paying them directly for their collateral costs to receive reproductive or gender-affirming health care services in the state.

EFFECTIVE DATE: July 1, 2025

Required Investment Standards

The bill requires the treasurer to invest the account's funds in a manner reasonable and appropriate to achieve the account's objectives. In doing so, he must exercise the discretion and care of a prudent person in similar circumstances with similar objectives. The treasurer must give due consideration to rate of return risk; term or maturity; diversification of the account's total portfolio; liquidity; projected disbursements and expenditures; and expected payments, deposits, contributions, and gifts to be received.

The account's funds must be continuously invested and reinvested in a way consistent with its objectives until they are disbursed as set forth in the bill.

Board of Trustees

Under the bill, the safe harbor account is administered by a five-member board of trustees. The board includes the state treasurer or his designee (who serves as the board's chairperson) and four treasurer-appointed members, including (1) one in-state provider of reproductive health care services, (2) one person experienced in working with the LGBTQ+ community, (3) one person experienced in working with reproductive health care providers, and (4) one person experienced in

working with providers of health care or mental health services to the LGBTQ+ community.

When making his appointments, the treasurer must use his best efforts to ensure that the board reflects the state's racial, gender, and geographic diversity.

Board Policies and Procedures

The bill requires the board of trustees, by September 1, 2025, to adopt policies and procedures on awarding these grants, including (1) application procedures, including procedures for subgrants; (2) eligibility criteria for applicant nonprofits, including subgrantees, and for people served by the grants; (3) eligibility criteria for collateral costs; (4) considerations of need for people served by the grants, including the urgency or time sensitivity and financial need; and (5) ways to coordinate with any national network that performs similar functions, including on accepting funding transferred to the account for a particular use. The policies and procedures must not condition grant eligibility on the collection or retention of patient-identifiable data.

The bill allows the board, as it deems necessary, to update the policies and procedures. It also allows the board to make a fact-based eligibility determination if it decides that the policies and procedures are inadequate to determine (1) a particular provider's or organization's eligibility or (2) whether a provider or nonprofit may use grant money to reimburse or pay for a certain service or collateral cost.

§§ 6 & 7 — OPIOID USE DISORDER

Declares opioid use disorder to be a public health crisis in the state and requires the Alcohol and Drug Policy Council to convene a working group to set goals to combat this disorder's prevalence

The bill requires the state's Alcohol and Drug Policy Council to convene a working group to set one or more goals for the state in its efforts to combat the prevalence of opioid use disorder. The council must report on these goals to the Public Health Committee by July 1, 2026.

The bill also declares that opioid use disorder is a public health crisis

in Connecticut and will continue as one until the state meets the working group's goals.

EFFECTIVE DATE: Upon passage

§ 8 — PUBLIC HEALTH URGENT COMMUNICATION ACCOUNT

Creates an account to fund DPH communications during public health emergencies

The bill creates the public health urgent communication account as a separate, nonlapsing account that must contain any money required by law to be deposited into it.

Under the bill, DPH must use the account's funds to give the public, health care providers, and other stakeholders timely, effective communication during a governor-declared public health emergency.

EFFECTIVE DATE: Upon passage

§ 9 — EMERGENCY PUBLIC HEALTH FINANCIAL SAFEGUARD ACCOUNT

Creates an account to address unexpected shortfalls in public health funding

The bill creates the emergency public health financial safeguard account as a separate, nonlapsing account that must contain any money required by law to be deposited into it.

Under the bill, DPH must use the account's funds to (1) address unexpected shortfalls in public health funding and (2) ensure the department's ability to respond to the state's health care needs and provide essential public health services. But the bill specifically prohibits DPH from using the account for any of the purposes for which the safe harbor account may be used (see § 5).

EFFECTIVE DATE: Upon passage

§ 10 — SUDEP INFORMATION

Requires physicians, APRNs, and PAs who regularly treat patients with epilepsy to give them information on sudden unexpected death in epilepsy

Starting October 1, 2025, the bill requires physicians, advanced practice registered nurses (APRNs), and physician assistants (PAs) who regularly treat patients with epilepsy to inform them about sudden

unexpected death in epilepsy (SUDEP), which is death among people with epilepsy not caused by injury, drowning, or other known unrelated causes. Specifically, they must give patients information on the risks of SUDEP and ways to mitigate those risks.

EFFECTIVE DATE: July 1, 2025

§ 11 — AEDS AT CERTAIN LONG-TERM CARE FACILITIES

Requires nursing homes and certain managed residential communities to have an AED in a central location

The bill requires administrators of nursing homes and managed residential communities (MRCs), by January 1, 2026, to have and maintain an automated external defibrillator (AED) in a central location at the home or MRC. They must (1) make the AED's location known and accessible to staff members and residents and their visiting family members and (2) maintain and test the AED according to the manufacturer's guidelines.

Under the bill, as under existing law, MRCs are facilities consisting of private residential units that provide a managed group living environment for people who are primarily age 55 or older. The bill excludes (1) state-funded congregate housing facilities, (2) elderly housing complexes receiving assistance and funding through the U.S. Department of Housing and Urban Development's Assisted Living Conversion Program, and (3) affordable housing units subsidized under DSS's assisted living demonstration project.

EFFECTIVE DATE: October 1, 2025

Background — Related Bill

sSB 1190 (File 22), favorably reported by the Public Health Committee, has similar provisions on AEDs at certain long-term care facilities.

§ 12 — PANCREATIC CANCER SCREENING PROGRAM

Requires DPH, within available appropriations, to create a pancreatic cancer screening and treatment referral program

The bill requires the DPH commissioner, by January 1, 2026, and

within available appropriations, to establish a pancreatic cancer screening and treatment referral program within DPH.

The program must (1) promote pancreatic cancer screening and detection among people who may be susceptible to the disease due to higher risk factors; (2) educate the public, including unserved and underserved populations (see below), about this cancer and the benefits of early detection; and (3) provide referrals to appropriate screening, counseling services, and treatment referral services.

The bill requires the program to include creating a public education and outreach initiative to publicize (1) pancreatic cancer screening services and the extent of health coverage that may be available for them; (2) the benefits of early detection and the recommended frequency of screening services, including clinical examinations; and (3) Medicaid and any other public or private program that patients may use to access these services.

The program must link to, and coordinate with, screening and counseling and treatment referral services offered by hospital systems, health care entities, and providers recognized by DPH. The program must also use and distribute professional education programs on the benefits of early detection of pancreatic cancer and the recommended screening frequency.

Under the bill, "unserved or underserved populations" are patients (1) at or below 250% of the federal poverty level for individuals (250% is $39,125 for 2025); (2) without health coverage for pancreatic cancer screening services; and (3) of an age at which these screening services are deemed appropriate by medical professionals.

EFFECTIVE DATE: October 1, 2025

Background — Related Bill

sSB 1191 (File 7), favorably reported by the Public Health Committee, requires the commissioner, within available appropriations, to establish a pancreatic cancer screening and treatment referral program within DPH (with services provided by outside providers).

§ 13 — EMS ADMINISTERING GLUCAGON NASAL POWDER

Requires EMS personnel to receive training on administering glucagon and allows them to administer glucagon nasal powder when necessary

The bill allows emergency medical services (EMS) personnel to administer glucagon nasal powder. Generally, "glucagon nasal powder" is a class of intranasally-administered medications used to treat severe low blood sugar in people with diabetes.

In order to administer glucagon nasal powder, the EMS professional must (1) be trained in administering injectable glucagon and (2) determine that administering glucagon is necessary to treat the patient.

The bill requires all EMS personnel to receive this training from an organization designated by the DPH commissioner. It also allows licensed or certified ambulances to have glucagon nasal powder for EMS personnel to administer as described above.

Under the bill, "EMS personnel" are (1) certified emergency medical responders; (2) any class of certified emergency medical technicians (EMTs), including advanced EMTs; and (3) licensed paramedics.

EFFECTIVE DATE: Upon passage

Background — Related Bill

sSB 1324 (File 79), favorably reported by the Public Health Committee, has similar provisions on EMS personnel administering glucagon nasal powder.

§ 14 — HOSPITAL FINANCIAL ASSISTANCE PORTAL

Requires OHA to contract with a vendor to develop an online hospital financial assistance portal for patients and their family members

The bill requires the Office of the Healthcare Advocate (OHA) to contract with a vendor to develop an online hospital financial assistance portal for patients and family members.

Under the bill, the portal must serve as a navigation tool to help patients and family members identify and apply for hospital financial assistance at Connecticut hospitals that would partially or fully reduce patients' liability for the cost of care. At a minimum, the portal may

include:

1. technical assistance and tools that streamline the application process for assistance,

2. a screening tool to help determine whether patients may be eligible for assistance, and

3. information to help patients and family members avoid future medical debt.

The bill also authorizes OHA to (1) consult with the Office of Policy and Management and publish information about the state's medical debt erasure initiative on the OHA website (see *Background – Medical Debt Erasure Initiative*) and (2) develop, in consultation with relevant organizations, recommendations on the initiative that may help patients and family members avoid future medical debt, including ways to streamline the hospital financial assistance application process.

Starting July 1, 2026, hospitals that offer financial assistance programs must give OHA contact information for their programs (i.e. website links, email addresses, and phone numbers). If a hospital revises the program's application form or contact information or establishes a new program, it must notify OHA and give the office any new program contact information within 30 days after doing so.

EFFECTIVE DATE: July 1, 2025

Background — Medical Debt Erasure Initiative

PA 23-204, as amended by PA 24-81, allocated $6.5 million in federal American Rescue Plan Act (ARPA) funds for the state to enter a partnership with Undue Medical Debt, a national nonprofit organization. Undue Medical Debt uses these funds to negotiate with hospitals and other health care providers to eliminate large, bundled portfolios of certain medical debt.

To qualify for medical debt erasure, patients must have (1) income at or below 400% of the federal poverty level (e.g., $84,600 for a family of

two in 2025) or (2) medical debt that is at least 5% of their income. Patients do not apply for the debt relief. Instead, they are notified by Undue Medical Debt if their debt has been identified for erasure.

During the initiative's first round in December 2024, the state invested approximately $100,000 in ARPA funds to acquire approximately $30 million in qualifying medical debt. During the second round this spring, the state invested $575,000 in ARPA funding, and Undue Medical Debt acquired and eliminated more than $100 million in qualifying medical debt.

Background — Related Bill

sSB 1192 (File 8), favorably reported by the Public Health Committee, has similar provisions on a hospital financial assistance portal.

§ 15 — FOOD CODE REVISIONS

Requires the DPH commissioner to adopt into the state's food code any FDA food code revision issued by the end of 2024, and gives her the discretion to adopt other supplements to the federal code

Existing law requires the DPH commissioner to adopt the FDA Food Code as the state's food code for regulating food establishments, and DPH regulations doing so took effect in early 2023. The bill requires the commissioner to adopt into the state code any FDA code revision issued by December 31, 2024. It gives her the discretion to adopt into the state code other supplements to the federal code, rather than requiring her to as under current law.

EFFECTIVE DATE: Upon passage

Background — Related Bill

SB 1326, § 2 (File 288), favorably reported by the Public Health Committee, has identical provisions on the food code.

§§ 16-18 — HOME HEALTH AND HOSPICE

Makes various changes to laws on home health and hospice agency staff safety, such as (1) requiring health care providers to give these agencies certain information when referring or transferring a patient to them, (2) extending to hospice agencies certain requirements that already apply to home health agencies, and (3) requiring these agencies to create a system for staff to report violent incidents or threats

The bill makes various changes to laws on staff safety for home health care and home health aide agencies ("home health agencies"), and extends some of these provisions to hospice agencies (i.e. organizations that provide home care and hospice services to terminally ill patients).

It requires health care providers, when referring or transferring a patient to a home health agency, to give the agency any documentation or information the provider has on the topics that the agency must collect during client intake (generally client and service location information; see *Background — Home Health Agency Client Intake Data Collection*). It similarly requires providers to give this information to hospice agencies. These provisions apply to the extent it is feasible and consistent with other state or federal laws.

Existing law, unchanged by the bill, does not require DPH-licensed hospice organizations to collect this information at client intake. The bill also specifically exempts from this data collection requirement agencies that operate solely as a (1) hospice agency, (2) home health care agency hospice program, (3) hospice-based home care program, or (4) hospice inpatient facility.

The bill extends to hospice agencies requirements to comply with certain safety-related training requirements (or risk losing Medicaid reimbursement if they fail to provide the training). Currently, these requirements apply only to home health agencies.

Current law requires home health agencies to conduct monthly safety assessments with direct care staff at the agency's monthly staff meeting. The bill extends this requirement to hospice agencies, and allows any of these agencies to complete the assessment through in-person or virtual meetings or other communication methods, including email, phone calls, text messages, a hotline, or a reporting portal. It also requires these

agencies to create a system for staff to promptly report violent incidents or potential threats, along with the safety assessments.

Current law authorizes the Department of Social Services (DSS) commissioner to increase Medicaid rates for home health agencies that report workplace violence incidents to DSS and DPH within seven calendar days after they happen. The bill (1) specifies that DSS may do so only within available appropriations and (2) extends this provision to hospice agencies.

Existing law also requires home health agencies to annually report to DPH on (1) each instance of a client's verbal abuse that a staff member perceived as a threat or danger, physical or sexual abuse, or any other client abuse of a staff member and (2) the actions they took to ensure the affected staff member's safety. The bill requires these agencies to report threats or abuse against staff members by anyone, not just clients, if related to the staff member's employment. It also extends this reporting requirement to hospice agencies. As under existing law, DPH must annually report on the collected information to the Public Health Committee.

EFFECTIVE DATE: October 1, 2025

Hospice Worker Safety Training

The bill extends to hospice agencies safety training requirements that currently only apply to home health agencies. Specifically, it requires hospice agencies to adopt and implement a home care worker health and safety training curriculum consistent with the one endorsed by the federal (1) CDC's National Institute for Occupational Safety and Health and (2) Occupational Safety and Health Administration, including training to recognize and manage common home care workplace hazards and practical ways to manage risks and improve safety. Hospice agencies must provide annual staff training that aligns with this curriculum.

Under the bill, the DSS commissioner must generally require these agencies to provide evidence that they adopted and implemented the

above training curriculum to continue receiving Medicaid reimbursements. The commissioner, at her discretion, may approve alternative applicable training programs.

Background — Home Health Agency Client Intake Data Collection

The law generally requires home health agencies to collect certain information during intake with a prospective client and give it to any employee assigned to the client, to the extent it is feasible and consistent with other laws. Specifically, this includes information on the following:

1. the client, including, if applicable, the client's history of violence against health care workers, domestic abuse, or substance use; a list of the client's diagnoses, including psychiatric history; whether the client's diagnoses or symptoms have been stable over time; and any information on violent acts involving the client from judicial records or any sex offender registry data concerning the client; and

2. the service location, including, if known to the agency, the municipality's crime rate, as determined by the most recent state crime annual report issued by the Department of Emergency Services and Public Protection; the presence of hazardous materials (including used syringes), firearms or other weapons, or other safety hazards; and the status of the location's fire alarm system.

Background — Related Bill

sSB 1451 (File 297), favorably reported by the Public Health Committee, contains generally similar provisions on home health care and hospice agencies.

§ 19 — EVALUATION OF DOC HEALTH CARE SERVICES

Requires the correction ombuds to evaluate health care services for incarcerated individuals, and specifies certain steps he may take when doing so

The bill specifically requires the state's correction ombuds to evaluate the provision of health care services to people who are incarcerated by the Department of Correction (DOC). This must include medical, dental, and mental health care and substance use disorder treatment services.

In doing so, the ombuds may do the following:

1. receive, investigate, and respond to complaints on DOC health care access or quality;

2. employ or contract with licensed health care professionals to provide independent clinical reviews of these complaints, when necessary;

3. collect and analyze health-related data across correctional facilities, including on appointment wait times, mental health care access, medication access and continuity, hospitalizations, and mortalities; and

4. make recommendations to DOC, DPH, and the Judiciary and Public Health committees on necessary improvements in the delivery of health care services within correctional facilities.

Existing law requires the ombuds to annually report to the Judiciary Committee on (1) the conditions of confinement within the state's correctional facilities and halfway houses and (2) his findings and recommendations. The bill specifically requires the report to address the delivery of health care in these settings, and include recommendations for any improvements in health care service delivery.

The bill also updates terminology and makes other technical changes.

EFFECTIVE DATE: October 1, 2025

Background — Related Bills

sSB 1394 (File 90), favorably reported by the Public Health Committee, requires the correction ombudsman to report on the provision of health care and mental health care services to incarcerated individuals, and requires other reports related to this topic.

sSB 1543, § 1 (File 801), favorably reported by the Judiciary and Appropriations committees, specifically requires DOC's plan for health care services to ensure that various requirements are met, rather than to include guidelines for implementing them, and expands upon the plan's

required mental health-related components.

§ 20 — CONSERVATOR APPOINTMENT EXPEDITED PROCESS

Requires the probate court administrator and DSS commissioner to evaluate the feasibility of establishing an expedited process to appoint a conservator for hospital emergency department patients who lack the capacity to consent to services

The bill requires the probate court administrator and DSS commissioner to evaluate the feasibility of establishing an expedited process to appoint a conservator for hospital emergency department patients who lack the capacity to consent to services. This process's purpose is to ensure that these patients receive timely services and to help reduce emergency department crowding and boarding (that is, keeping patients in the department while they await inpatient beds). By January 1, 2026, they must jointly report on the evaluation and any legislative recommendations to the Public Health Committee.

EFFECTIVE DATE: Upon passage

Background — Temporary Conservator Appointments

By law, the probate court may appoint a temporary conservator if, upon the petition of certain parties (e.g., a spouse or other relative), it finds that (1) the respondent cannot manage his or her affairs or care for himself or herself, (2) immediate and irreparable harm to the person's mental or physical health or financial or legal affairs will result without the appointment, and (3) the appointment is the least restrictive available way to prevent this harm. A physician generally must have examined the person and made certain findings.

Under some circumstances, if the court determines that delay would cause immediate and irreparable harm, it can order the appointment ex parte and without prior notice to the respondent. In these cases, it must hold the required hearing within three days after the order (excluding weekends and holidays) (CGS § 45a-654).

Background — Related Bill

sSB 1538, § 2 (File 713), favorably reported by the Public Health Committee, has identical provisions on such an evaluation.

§ 21 — HOSPITAL REPORTING ON EMERGENCY DEPARTMENTS

Adds to the required recipients of hospitals' annual reports analyzing emergency department data

Existing law generally requires hospitals to annually analyze certain emergency department data toward the goals of (1) developing ways to reduce admission wait times, (2) informing potential ways to improve admission efficiencies, and (3) examining root causes for admission delays. By each March 1 (until 2029) they must annually report to the Public Health Committee on their findings and recommendations. This bill requires them to also submit these reports to the DPH and Office of Health Strategy (OHS) commissioners and the Healthcare Advocate.

EFFECTIVE DATE: Upon passage

Background — Related Bill

sSB 1538, § 1 (File 713), favorably reported by the Public Health Committee, requires hospitals to submit these reports to the DPH and OHS commissioners.

§ 22 — HOSPITAL DISCHARGE WORKING GROUP

Creates a working group on hospital discharge challenges

The bill creates a 22-member working group to evaluate hospital discharge challenges, including discharge practices, and propose strategies to reduce discharge delays, improve care transitions, and alleviate emergency department boarding. By January 15, 2026, the group must report its findings and recommendations to the Human Services and Public Health committees.

Under the bill, the Public Health Committee's administrative staff serves in that capacity for the working group.

EFFECTIVE DATE: Upon passage

Working Group Membership

The group consists of the DPH, OHS, DSS, and insurance commissioners or their designees, and the following members appointed by the Public Health Committee chairpersons and ranking members:

1. two hospital administrators (specifically, chief operating officers or vice presidents of care coordination), one from an urban hospital and one from a rural one;
2. two emergency department physicians, nominated by an in-state college of emergency physicians;
3. one practicing hospitalist with discharge planning experience;
4. two health system executives, one from a community hospital;
5. one representative each from (a) a Connecticut-licensed commercial health insurer, (b) a care management organization under a Medicaid care management contract with the state, (c) a skilled nursing facility, (d) a home health or community-based care organization, (e) a patient advocacy organization with care transition expertise, and (f) an in-state hospital association;
6. one behavioral health provider involved in discharge transitions;
7. one primary care physician affiliated with a clinically integrated network;
8. one academic or public health policy expert from an in-state higher education institution; and
9. one member each from the Public Health and Human Services committees, as nonvoting members.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 21 Nay 10 (03/27/2025)

Judiciary Committee

Joint Favorable
Yea 29 Nay 11 (05/12/2025)

Appropriations Committee

Joint Favorable
Yea 35 Nay 13 (05/16/2025)