House of Representatives

File No. 903

General Assembly

January Session, 2025

(Reprint of File No. 107)

Substitute House Bill No. 6771
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
May 12, 2025

AN ACT ESTABLISHING AN ALZHEIMER'S DISEASE AND DEMENTIA TASK FORCE, REQUIRING HEALTH INSURANCE COVERAGE FOR BIOMARKER TESTING AND CONCERNING TRANSFERS AND DISCHARGES IN RESIDENTIAL CARE HOMES, TUITION WAIVERS FOR NURSING HOME RESIDENTS WHO TAKE COURSES AT REGIONAL COMMUNITY-TECHNICAL COLLEGES AND CLOSURES AND EVACUATIONS OF RESIDENTIAL CARE HOMES AND NURSING HOMES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsections (a) to (c), inclusive, of section 19a-491c of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2025*):

(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 care agency, hospice agency or home health aide 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-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.

(b) The Department of Public Health shall create and implement a criminal history and patient abuse background search program, within available appropriations, in order to facilitate the performance, processing and analysis of the criminal history and patient abuse background search of **[**individuals who have direct access**]** (1) any

individual (A) to whom a long-term care facility will extend an offer of employment, or (B) with whom a long-term care facility will enter into a contract for the provision of long-term care services, and (2) any volunteer who a long-term care facility reasonably expects will regularly perform duties that are substantially similar to those of an employee with direct access.

(c) (1) Except as provided in subdivision (2) of this subsection, each long-term care facility, prior to extending an offer of employment to, or entering into a contract for, the provision of long-term care services with any individual, **[**who will have direct access,**]** or prior to allowing any individual to begin volunteering at such long-term care facility when the long-term care facility reasonably expects such volunteer will regularly perform duties that are substantially similar to those of an employee with direct access, shall require that such individual submit to a background search. The Department of Public Health shall prescribe the manner by which (A) long-term care facilities perform the review of (i) the registry of nurse's aides maintained by the department pursuant to section 20-102bb, and (ii) any other registry specified by the department, including requiring long-term care facilities to report the results of such review to the department, and (B) individuals submit to state and national criminal history records checks, including requiring the Department of Emergency Services and Public Protection to report the results of such checks to the Department of Public Health.

(2) No long-term care facility shall be required to comply with the provisions of this subsection if (A) the individual provides evidence to the long-term care facility that such individual submitted to a background search conducted pursuant to subdivision (1) of this subsection not more than three years immediately preceding the date such individual applies for employment, seeks to enter into a contract or begins volunteering with the long-term care facility and that the prior background search confirmed that the individual did not have a disqualifying offense, or (B) the commissioner determines the need to temporarily suspend the requirements of this subsection in the event of an emergency or significant disruption. The commissioner shall inform

the long-term care facility when the commissioner has suspended the requirements of this subsection pursuant to subparagraph (B) of this subdivision and when such suspension is rescinded.

Sec. 2. (NEW) (*Effective October 1, 2025*) (a) There is established an Alzheimer's Disease and Dementia task force. The task force shall:

(1) Examine (A) the needs of persons living with Alzheimer's disease or dementia in the state, (B) the services available to such persons and their family caregivers, and (C) the ability of health care providers and institutions to meet the needs of such persons; and

(2) Develop a State Alzheimer's Plan, which shall make findings and recommendations regarding:

(A) State residents living with Alzheimer's disease and dementia and their service needs, including, but not limited to, (i) the state's role in providing or facilitating long-term care, family caregiver support and assistance to persons with early-stage and early-onset Alzheimer's disease or dementia, (ii) state policies regarding persons living with Alzheimer's disease or dementia, and (iii) the fiscal impact of Alzheimer's disease and dementia on publicly funded health care programs;

(B) Existing resources, services and capacity relating to the diagnosis and care of persons living with Alzheimer's disease or dementia, including, but not limited to, (i) the type, cost and availability of dementia care services, (ii) the availability of health care providers who can provide Alzheimer's disease or dementia-related services, including, but not limited to, neurologists, geriatricians and direct care workers, (iii) dementia-specific training requirements for public and private employees who interact with persons living with Alzheimer's disease or dementia, including, but not limited to, long-term care providers, case managers, adult protective services employees and law enforcement personnel and other first responders, (iv) home and community-based services, including, but not limited to, respite care services, (v) quality of care measures for home and community-based

services and residential care facilities, and (vi) state-supported Alzheimer's disease and dementia research conducted at higher education institutions located in the state; and

(C) Policies and strategies that (i) increase public awareness of Alzheimer's disease and dementia, (ii) educate health care providers to increase early detection and diagnosis of Alzheimer's disease and dementia, (iii) improve health care services for persons living with Alzheimer's disease or dementia, (iv) evaluate the capacity of the health care system in meeting the growing number and needs of persons living with Alzheimer's disease or dementia, (v) increase the number of health care providers available to treat the growing aging population and populations living with Alzheimer's disease or dementia, (vi) improve services provided in the home and community to delay and decrease the need for institutionalized care for persons living with Alzheimer's disease or dementia, (vii) improve long-term care services, including, but not limited to, assisted living services for persons living with Alzheimer's disease or dementia, (viii) assist unpaid Alzheimer's disease and dementia caregivers, (ix) increase and improve research on Alzheimer's disease and dementia, (x) promote activities to maintain and improve brain health, (xi) improve data and information collection relating to Alzheimer's disease and dementia and the public health burdens associated with such diseases, (xii) improve public safety and address the safety-related needs of persons living with Alzheimer's disease or dementia, (xiii) address legal protections for, and legal issues faced by, persons living with Alzheimer's disease or dementia, and (xiv) improve methods through which the state evaluates and adopts policies to assist persons living with Alzheimer's disease or dementia.

(b) The task force shall consist of the following members:

(1) Eleven members appointed by the Governor, (A) one of whom shall be a person living with early-stage or early-onset Alzheimer's disease or dementia, (B) one of whom shall be a family caregiver of a person living with Alzheimer's disease or dementia, (C) one of whom shall represent a municipality that provides services to senior citizens,

(D) one of whom shall represent home health care agencies, (E) two of whom shall be health care providers with experience diagnosing and treating Alzheimer's disease, (F) one of whom shall represent a national organization that advocates on behalf of persons living with Alzheimer's disease or dementia, (G) one of whom shall represent the area agencies on aging, established pursuant to section 17a-850 of the general statutes, (H) one of whom shall represent long-term care facilities, (I) one of whom shall have expertise in aging policy issues, and (J) one of whom shall represent homemaker-companion agencies;

(2) The Commissioner of Aging and Disability Services, or the commissioner's designee;

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

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

(5) The State Ombudsman, or the State Ombudsman's designee.

(c) All initial appointments to the task force shall be made not later than January 1, 2026. Task force members first appointed pursuant to subparagraphs (A) to (D), inclusive, of subdivision (1) of subsection (b) of this section shall serve for a term of two years. Task force members first appointed pursuant to subparagraphs (E) to (J), inclusive, of subdivision (1) of subsection (b) of this section shall serve for a term of three years. Any subsequent task force member appointed pursuant to subdivision (1) of subsection (b) of this section shall serve for a term of two years, or until such member's successor is appointed. If the Governor determines that no suitable successor candidate exists to appoint to the task force, the Governor may reappoint an existing task force member for one two-year term.

(d) The Commissioner of Aging and Disability Services, or the commissioner's designee, shall convene the first meeting of the task force not later than thirty days after all task force members are

appointed. At such meeting, the members of the task force shall select a chairperson and vice chairperson from among the members of the task force. The chairperson and vice chairperson may serve in such roles not more than two consecutive years. The task force shall meet not less than once every calendar quarter.

(e) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to aging shall serve as administrative staff of the task force.

(f) Not later than January 1, 2027, and annually thereafter, the task force shall submit a report on the State Alzheimer's Plan to the Governor and, in accordance with the provisions of section 11-4a of the general statutes, the joint standing committees of the General Assembly having cognizance of matters relating to aging, public health and human services. Such report shall include recommendations for the implementation of the State Alzheimer's Plan and identify any barriers to the implementation of such plan. The task force shall update the State Alzheimer's Plan every four years.

Sec. 3. Section 19a-535a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2025*):

(a) As used in this section:

(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 the resident's 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 permit each resident to remain in the facility, and 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.

(c) In the case of an involuntary transfer or discharge, the facility shall, in a form and manner prescribed by the commissioner, provide written notice to the resident and, if known, the resident's legally liable relative, guardian or conservator not less than 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)] (f) of this section. Such notice shall include (1) the reason for the transfer or discharge, (2) the effective date of the transfer or discharge, (3) the location to which the resident will be transferred or discharged, (4) the right of the resident to appeal a transfer or discharge by the facility pursuant to subsection [(d)] (e) of this section, [and] (5) 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] (6) the name, mailing address and telephone number of the State Long-Term Care Ombudsman, and (7) an attestation by the facility that such notice has been submitted to the Internet web site portal maintained by the State Ombudsman in accordance with subsection (h) of this section. Such notice shall be submitted to the Internet web site portal maintained by the State Ombudsman on the same day such notice is provided 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. If any information provided in a notice provided pursuant to the provisions of this subsection changes prior to effecting the transfer or discharge of a resident, the facility shall update each recipient of the notice in writing as soon as practicable once the updated information becomes available. 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)**]** (d) The facility shall be responsible for assisting the resident in finding an alternative residence and, in providing such assistance, shall consider the resident's proximity to family members and any other known support networks. A discharge plan, prepared by the facility, in a form and manner prescribed by the commissioner, as modified from time to time, shall include the resident's individual needs and shall be submitted to the resident not later than seven days after the notice of transfer or 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)**]** (e) of this section.

[(d)**]** (e) (1) A resident or the resident's legally liable relative, guardian or conservator who has been notified by a facility, pursuant to subsection **[**(b)**]** (c) of this section, that the resident 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 (A) not later than ten days after the receipt of such notice, or (B) if the facility updates the location to which the resident will be transferred or discharged pursuant to subsection (c) of this section, not later than ten days after the receipt of such update, provided any involuntary transfer or discharge shall be stayed during such ten-day period. Upon receipt of any such request, the commissioner 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 not later than seven business days after the receipt of such request. 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 chapter 54.

(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 the 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)**]** (f) (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 and the notice described in subsection **[**(b)**]** (c) of this section to the resident. 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 not 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 date on which a determination is issued pursuant to this section. The commissioner shall issue a decision not later than twenty days after the date on which the hearing record is closed. The hearing shall be conducted in accordance with the provisions of chapter 54.

(2) The commissioner shall send a copy of the 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)**]** (e) of this section.

[(f)**]** (g) 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 the 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 pursuant to this section as a privileged case in order to dispose of the case with the least possible delay.

[(g) Not later than six months after May 23, 2022, a**]** (h) A facility shall electronically report each involuntary transfer or discharge (1) in a manner prescribed by the State Ombudsman, appointed pursuant to section 17a-405, and (2) on an Internet web site portal maintained by the State Ombudsman in accordance with patient privacy provisions of the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time.

Sec. 4. (NEW) (*Effective January 1, 2026*) (a) As used in this section:

(1) "Biomarker" means a characteristic, including, but not limited to, a gene mutation or protein expression that can be objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention for a disease or condition.

(2) "Biomarker testing" means the analysis of a patient's tissue, blood or other biospecimen for the presence of a biomarker, including, but not

limited to, tests for a single substance, tests for multiple substances and diseases or conditions. "Biomarker testing" does not include an evaluation of how a patient feels, functions or survives.

(3) "Clinical utility" means the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision.

(4) "Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options intended to optimize patient care developed by independent organizations or medical professional societies utilizing transparent methodologies and reporting structures and conflict-of-interest policies.

(b) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2026, shall provide coverage for biomarker testing for the purpose of diagnosis, treatment, appropriate management or ongoing monitoring of an insured's disease or condition, provided such biomarker testing provides clinical utility as demonstrated by medical and scientific evidence, including, but not limited to, one or more of the following: (1) Approval or clearance of such test by the federal Food and Drug Administration or recommendations on labels of drugs approved by the federal Food and Drug Administration to conduct such test, (2) national coverage determinations or local coverage determinations for Medicare Administrative Contractors by the Centers for Medicare and Medicaid Services, or (3) nationally recognized clinical practice guidelines. Such policy shall provide such coverage in a manner that limits disruptions in care, including, but not limited to, the need for multiple biopsies or biospecimen samples. Such policy may require that biomarker testing be performed at an in-network clinical laboratory, as defined in section 19a-490 of the general statutes.

(c) Each entity providing such coverage shall establish a clear, readily accessible and convenient process through which an insured or an insured's health care provider may (1) request an exception to a coverage policy, or (2) dispute an adverse utilization review determination relating to such coverage. Each such entity shall post such process on the Internet web site maintained by such entity.

(d) If prior authorization is required before providing such coverage, each entity providing such coverage or each utilization review entity or other third party acting on behalf of such entity shall approve or deny such prior authorization and notify the insured, the insured's health care provider and any other entity requesting such prior authorization of such approval or denial (1) if the prior authorization is not urgent, as determined by the insured's health care provider, not later than seven days after receiving a prior authorization request, or (2) if the prior authorization is urgent, as determined by the insured's health care provider, not later than seventy-two hours after receiving a prior authorization request.

Sec. 5. (NEW) (*Effective January 1, 2026*) (a) As used in this section:

(1) "Biomarker" means a characteristic, including, but not limited to, a gene mutation or protein expression that can be objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention for a disease or condition.

(2) "Biomarker testing" means the analysis of a patient's tissue, blood or other biospecimen for the presence of a biomarker, including, but not limited to, tests for a single substance, tests for multiple substances and diseases or conditions. "Biomarker testing" does not include an evaluation of how a patient feels, functions or survives.

(3) "Clinical utility" means the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision.

(4) "Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options intended to optimize patient care developed by independent organizations or medical professional societies utilizing transparent methodologies and reporting structures and conflict-of-interest policies.

(b) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2026, shall provide coverage for biomarker testing for the purpose of diagnosis, treatment, appropriate management or ongoing monitoring of an insured's disease or condition, provided such biomarker testing provides clinical utility as demonstrated by medical and scientific evidence, including, but not limited to, one or more of the following: (1) Approval or clearance of such test by the federal Food and Drug Administration or recommendations on labels of drugs approved by the federal Food and Drug Administration to conduct such test, (2) national coverage determinations or local coverage determinations for Medicare Administrative Contractors by the Centers for Medicare and Medicaid Services, or (3) nationally recognized clinical practice guidelines. Such policy shall provide such coverage in a manner that limits disruptions in care, including, but not limited to, the need for multiple biopsies or biospecimen samples. Such policy may require that biomarker testing be performed at an in-network clinical laboratory, as defined in section 19a-490 of the general statutes.

(c) Each entity providing such coverage shall establish a clear, readily accessible and convenient process through which an insured or an insured's health care provider may (1) request an exception to a coverage policy, or (2) dispute an adverse utilization review determination relating to such coverage. Each such entity shall post such process on the Internet web site maintained by such entity.

(d) If prior authorization is required before providing such coverage, each entity providing such coverage or each utilization review entity or other third party acting on behalf of such entity shall approve or deny such prior authorization and notify the insured, the insured's health care provider and any other entity requesting such prior authorization of such approval or denial (1) if the prior authorization is not urgent, as determined by the insured's health care provider, not later than seven days after receiving a prior authorization request, or (2) if the prior authorization is urgent, as determined by the insured's health care provider, not later than seventy-two hours after receiving a prior authorization request.

Sec. 6. Subsection (d) of section 10a-77 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) Said board of trustees shall waive the payment of tuition at any of the regional community-technical colleges (1) for any dependent child of a person whom the armed forces of the United States has declared to be missing in action or to have been a prisoner of war while serving in such armed forces after January 1, 1960, which child has been accepted for admission to such institution and is a resident of the state at the time such child is accepted for admission to such institution, (2) subject to the provisions of subsection (e) of this section, for any veteran, as defined in section 27-103, who performed service in time of war, as defined in section 27-103, except that for purposes of this subsection, "service in time of war" shall not include time spent in attendance at a military service academy, which veteran has been accepted for admission to such institution and is domiciled in this state at the time such veteran is accepted for admission to such institution, (3) for any resident of the state <u>(A)</u> sixty-two years of age or older<u>, or (B) who is a resident of a nursing home, as defined in section 19a-490, and has maintained residency at such nursing home for not less than thirty days</u>, provided, at the end of the regular registration period, there are enrolled in the course a sufficient number of students other than those residents eligible for waivers pursuant to this subdivision to offer the course in which

such resident intends to enroll and there is space available in such course after accommodating all such students, (4) for any student attending the Connecticut State Police Academy who is enrolled in a law enforcement program at said academy offered in coordination with a regional community-technical college which accredits courses taken in such program, (5) for any active member of the Connecticut Army or Air National Guard who (A) has been certified by the Adjutant General or such Adjutant General's designee as a member in good standing of the guard, and (B) is enrolled or accepted for admission to such institution on a full-time or part-time basis in an undergraduate degree-granting program, (6) for any dependent child of a (A) police officer, as defined in section 7-294a, or supernumerary or auxiliary police officer, (B) firefighter, as defined in section 7-323j, or member of a volunteer fire company, (C) municipal employee, or (D) state employee, as defined in section 5-154, killed in the line of duty, (7) for any resident of the state who is a dependent child or surviving spouse of a specified terrorist victim who was a resident of this state, (8) for any dependent child of a resident of the state who was killed in a multivehicle crash at or near the intersection of Routes 44 and 10 and Nod Road in Avon on July 29, 2005, and (9) for any resident of the state who is a dependent child or surviving spouse of a person who was killed in action while performing active military duty with the armed forces of the United States on or after September 11, 2001, and who was a resident of this state. If any person who receives a tuition waiver in accordance with the provisions of this subsection also receives educational reimbursement from an employer, such waiver shall be reduced by the amount of such educational reimbursement. Veterans and members of the National Guard described in subdivision (5) of this subsection shall be given the same status as students not receiving tuition waivers in registering for courses at regional community-technical colleges. Notwithstanding the provisions of section 10a-30, as used in this subsection, "domiciled in this state" includes domicile for less than one year.

Sec. 7. Subsection (g) of section 19a-535 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from*

passage):

(g) The facility shall be responsible for assisting the resident in finding appropriate placement and, in providing such assistance, shall consider the resident's proximity to family members and any other known support networks.

Sec. 8. (*Effective from passage*) The State Ombudsman, in conjunction with the Commissioners of Public Health and Social Services, shall convene a working group to examine (1) residential care home evacuation procedures, and (2) whether to require residential care homes to participate in a mutual aid digital platform that supports the risk management needs of health care organizations, including dedicated solutions for emergency management, inspection, testing and maintenance management, inspections management and health care coalition management. The working group shall include not less than two representatives of residential care homes. Not later than January 1, 2026, the working group shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health and aging regarding the findings and recommendations of the working group.

Sec. 9. Subsection (h) of section 19a-533 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2025*):

(h) Notwithstanding the provisions of this section, a nursing home shall, without regard to the order of its waiting list, admit an applicant who (1) seeks to transfer from a nursing home that is closing, **[**or**]** (2) seeks to transfer from a nursing home in which the applicant was placed following the closure of the nursing home where such applicant previously resided or, in the case of a nursing home placed in receivership, the anticipated closure of the nursing home where such applicant previously resided, provided (A) the transfer occurs not later than sixty days following the date that such applicant was transferred

from the nursing home where he or she previously resided, and (B) except when the nursing home that is closing transferred the resident due to an emergency, the applicant submitted an application to the nursing home to which he or she seeks admission at the time of the applicant's transfer from the nursing home where he or she previously resided, or (3) seeks to transfer from a nursing home that (A) has filed a certificate of need request pursuant to section 17b-352 on which the Commissioner of Social Services has not issued a final decision, and (B) has five residents or less. A nursing home that qualifies for a waiting list exemption pursuant to subsection (f) or (g) of this section shall not be required to admit an indigent person under this subsection except when the resident is being transferred from a nursing home that is closing due to an emergency. No nursing home shall be required to admit an applicant pursuant to the provisions of this subsection if the nursing home has determined that (i) the applicant does not have a payor source because the applicant has been denied Medicaid eligibility or the applicant has failed to pay a nursing home that is closing for the three months preceding the date of the application for admittance and has no pending application for Medicaid, (ii) the applicant is subject to a Medicaid penalty period, or (iii) the applicant does not require nursing home level of care as determined in accordance with applicable state and federal requirements.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2025*	19a-491c(a) to (c)
Sec. 2	*October 1, 2025*	New section
Sec. 3	*October 1, 2025*	19a-535a
Sec. 4	*January 1, 2026*	New section
Sec. 5	*January 1, 2026*	New section
Sec. 6	*from passage*	10a-77(d)
Sec. 7	*from passage*	19a-535(g)
Sec. 8	*from passage*	New section
Sec. 9	*October 1, 2025*	19a-533(h)

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 26 $	FY 27 $
Resources of the General Fund	GF - Potential Revenue Gain	Minimal	Minimal
Department of Emergency Services and Public Protection	GF - Potential Cost	Minimal	Minimal
Department of Emergency Services and Public Protection	Applicant Fingerprint Card Submission Account - Potential Revenue Gain	Minimal	Minimal
State Comptroller - Fringe Benefits	GF - Potential Cost	Less than 100,000	Less than 200,000
Resources of the General Fund	GF - Potential Cost	Up to 92,000	Up to 184,000
Social Services, Dept.	GF - Potential Cost	See Below	See Below
Board of Regents for Higher Education	Other Fund - Potential Revenue Loss	Less than 100,000	Less than 100,000

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 26 $	FY 27 $
Various Municipalities	STATE MANDATE[1] - Potential Cost	See Below	See Below
Various Municipal Police Departments	Potential Revenue Gain	Minimal	Minimal

[1] State mandate is defined in Sec. 2-32b(2) of the Connecticut General Statutes, "state mandate" means any state initiated constitutional, statutory or executive action that requires a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.

Explanation

The bill contains various provisions, resulting in fiscal impacts as described by section below.

Section 1 requires all prospective employees and contractors of long-term care facilities to submit to fingerprint-based state criminal history records checks, resulting in: (1) a potential cost to the Department of Emergency Services and Public Protection (DESPP), (2) a potential revenue gain to the General Fund[2], and (3) a potential revenue gain to the Applicant Fingerprint Card Submission Account and various municipal police departments[3] in FY 26 and FY 27. The potential cost to DESPP will depend on the extent to which the volume of new applicants for state criminal history checks increases department workload and impacts overtime. It is unknown how many employers already require such applicants to submit to such checks as a condition of employment.

There is no anticipated cost to the Department of Public Health as the existing long-term care background search program can accommodate any increase in background checks resulting from the bill.

Section 2 establishes an Alzheimer's Disease and Dementia task force, which does not result in a fiscal impact to the agencies involved in the task force's activities.

Section 3 makes procedural and technical changes to the existing process documenting involuntarily transfers or discharges from a residential care home (RCH), which have no fiscal impact.

Sections 4 and 5 mandate that certain health insurance plans provide

[2]DESPP conducts state criminal history records checks for a fee of $75. The revenue that is collected from this fee is deposited into the General Fund.

[3]DESPP conducts fingerprinting for a fee of $15 fee per person paid to the Applicant Fingerprint Card Submission Account. Municipal police departments may also conduct the required fingerprinting for state criminal history records checks and typically charge a fee of $10 to $15.

biomarker testing coverage, which results in multiple potential costs.

State Employee Health Plan. There is a potential cost of less than $100,000 for the partial year coverage in FY 26 and less than $200,000 annually thereafter to the State Comptroller – Fringe Benefits for the anticipated per member per month increase to the state employee health plan (SEHP) associated with the mandated coverage of biomarker testing. The SEHP currently covers biomarker testing. Premiums for the SEHP are anticipated to increase by $0.10 per member per month, assuming a 5% utilization rate increase.

Municipalities. Costs related to the mandated coverage may also be incurred by fully insured municipalities and those participating in the State Partnership Plan (SPP). The mandated coverage of biomarker testing results in a potential cost less than $34,000 for the partial year coverage in FY 26 and less than $69,000 annually thereafter shared proportionately amongst municipalities in the SPP based on enrollment. The SPP currently covers biomarker testing. The potential cost accounts for an increase in utilization, and broader coverage for biomarker tests, which may impact plan premiums.

These estimates neglect any future cost saving offsets, and actual fiscal impacts will be realized in future premiums. Actual costs are dependent on the level of coverage, utilization, and number of those enrolled in each plan. Due to federal law, the coverage requirements will not apply to self-insured municipalities, as they are exempt under Employee Retirement Income Security Act (ERISA).

Exchange and Covered Connecticut. There is a potential cost to the state of up to $92,000 for the partial year coverage in FY 26 and up to $184,000 annually thereafter to defray additional premium costs for enrollees purchasing health insurance on the state's exchange. This cost is potential as it is incurred to the extent the new coverage requirements for biomarker testing are determined to increase premiums and constitute new state benefit mandates under the federal Affordable Care Act (ACA). Currently, the different plans in the exchange cover

biomarker testing. The potential cost accounts for an increase in utilization, and broader coverage for biomarker tests, which may impact plan premiums.

Under the ACA, states are allowed to mandate benefits beyond the federally-defined Essential Health Benefits (EHB) but must pay for that excess coverage. Federal regulations require the state to defray the cost of additional benefits related specific care, treatment or services mandated by state action after December 31, 2011 (except to comply with federal requirements) for all plans sold on the exchange.[4] There are currently 152,042 enrollees in qualified health plans on the exchange, including approximately 42,000 in Covered Connecticut.

To the extent the bill is determined to include a new state benefit mandate that requires defrayal, there would be a cost to the state beginning January 1, 2026.[5] Full year costs would begin in FY 27 and continue annually.

Defrayal costs for Covered Connecticut enrollees would be incurred by the Department of Social Services (DSS), to the extent the bill raises premiums for those enrollees.

Federal regulations allow states to update their EHB benchmark plans, potentially incorporating new benefit mandates without the need for defrayal for plan years beginning on January 1, 2020.[6] If the state integrates biomarker testing into its EHB benchmark and obtains federal approval, these benefits become part of the EHB. As a result, the state would not be required to defray the costs of biomarker testing.

Section 6 results in a potential revenue loss of less than $100,000 annually beginning in FY 26 to the Board of Regents for Higher Education. It waives tuition to CT State for nursing home residents who

[4] 45 CFR 155.170

[5] After determining if the mandate is subject to defrayal, states must reimburse the carriers or the insureds for the excess coverage. The premium costs are to be quantified by each insurer on the exchange and reported to the state.

[6] 45 CFR 156.111

are enrolled in courses.

As of September 30, 2023, there were approximately 19,600 nursing home residents in Connecticut. Of this population, approximately 15% was under the age of 65. Current law waives tuition at CT State for state residents over the age of 62 under certain circumstances. For this reason, the number of people who receive the bill's waiver is expected to be minimal. If 10 people received a waiver at the FY 26 full-time, in-state tuition rate of $4,608 for CT State, the revenue loss would be $46,080. If those ten people instead each took one, three-credit course at the rate of $576 for three credit hours, the revenue loss to CT State would be $5,760.

Section 7, which requires nursing homes and residential care homes to consider a resident's proximity to family members and other known support networks when assisting with a transfer or discharge, does not result in a fiscal impact to the state.

Section 8, which establishes a working group to examine RCH evacuation procedures and participation in a mutual aid digital platform, does not result in a fiscal impact to the state. Workload adjustments can be managed within the current staffing levels of the specified state agencies.

Section 9 modifies criteria mandating nursing homes to disregard their waiting lists to admit an applicant, which has no state fiscal impact.

House "A" strikes the underlying bill and its associated fiscal impact, and results in the impact described above.

The Out Years

The annualized ongoing fiscal impact of Section 1 identified above would continue into the future subject to the number of state criminal history records checks performed.

The annualized ongoing fiscal impact of Sections 4 and 5 identified above would continue into the future subject to inflation, cost of biomarker tests, utilization of biomarker testing, and federal regulations

regarding defrayal requirements.

The annualized ongoing fiscal impact of Section 6 identified above would continue into the future subject to inflation in CT State tuition.

OLR Bill Analysis

sHB 6771 (as amended by House "A")*

AN ACT REQUIRING HEALTH INSURANCE COVERAGE FOR BIOMARKER TESTING.

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§ 7 — NURSING HOME TRANSFERS
Requires certain long-term care facilities to consider closeness to support networks when a resident is being transferred from a facility

§ 8 — RESIDENTIAL CARE HOME WORKING GROUP
Establishes a working group to examine topics related to residential care homes

§ 9 — WAITING LIST EXEMPTION
Adds to the circumstances when nursing homes generally must ignore their waiting list when admitting residents who are transferring from another nursing home

SUMMARY

This bill makes changes related to the regulation and oversight of long-term care and similar licensed facilities, establishes an aging-related task force and working group, requires certain health care insurers to cover biomarker testing, and allows certain nursing home residents to take courses at the regional community-technical colleges tuition free, as described in the section-by section analysis below.

The bill also makes technical and conforming changes.

*House Amendment "A" makes certain changes to the underlying provisions on insurance coverage for biomarker testing, such as (1) allowing policies to require that the testing be done at in-network clinical laboratories and (2) removing a provision that would have required a study by the insurance commissioner. It also adds the provisions on (1) background checks for all employees of long-term care facilities, (2) an Alzheimer's and dementia task force, (3) transfers and discharges from various long-term care facilities, (4) tuition waivers for nursing home residents, (5) a working group on residential care homes, and (6) nursing home waiting lists.

EFFECTIVE DATE: October 1, 2025, unless otherwise noted below.

§ 1 — LONG-TERM CARE FACILITY EMPLOYEE BACKGROUND CHECKS

Requires all prospective employees of long-term care facilities to undergo, or have had within three years, a criminal history and patient abuse background check

Existing law requires the Department of Public Health to implement a criminal history and patient abuse background search program for employees and volunteers at long-term care facilities.

The bill requires all prospective employees at these facilities (whether direct hires or contracted positions), not just those who will have direct access to patients or residents as under current law, to undergo a criminal history and patient abuse background check. It retains the existing requirement that volunteers have a background check if the facility reasonably expects their duties will be substantially similar to employees with direct access to patients or residents.

As under existing law, facilities do not have to require a background search for a prospective employee or volunteer if the person provides evidence that one occurred no more than three years immediately before applying for the position (and no disqualifying offense was revealed).

Background — Related Bill

sHB 6774 (File 24), favorably reported by the Aging Committee, similarly requires all prospective employees of long-term care facilities to undergo a criminal history and patient abuse background check.

§ 2 — ESTABLISHING AN ALZHEIMER'S DISEASE AND DEMENTIA TASK FORCE

Establishes a 15-member Alzheimer's Disease and Dementia Task Force and requires it to develop a State Alzheimer's Plan

The bill establishes an Alzheimer's Disease and Dementia Task Force. The task force must (1) examine the needs of people living with Alzheimer's or dementia, services available to them and their family caregivers, and health care providers' ability to meet the needs of people living with Alzheimer's or dementia and (2) develop a State Alzheimer's Plan.

The bill requires the task force to annually report, beginning by January 1, 2027, to the governor and the Aging, Human Services, and

Public Health committees. The report must include recommendations for implementing the State Alzheimer's Plan and identify any implementation barriers. The bill requires the task force to update the plan every four years.

State Alzheimer's Plan

Service Needs. The plan must include findings and recommendations about the service needs of people living with Alzheimer's and dementia including the following:

1. the state's role in providing or facilitating long-term care, family caregiver support, and assistance to people with early-stage and early-onset Alzheimer's or dementia;

2. state policies regarding people living with Alzheimer's or dementia; and

3. the fiscal impact of Alzheimer's and dementia on publicly funded health care programs.

Existing Resources. The plan must also make findings and recommendations about the existing resources, services, and capacity to deliver those to people living with Alzheimer's or dementia, including the following:

1. the type, cost, and availability of dementia care services;

2. the availability of health care providers who can provide Alzheimer's or dementia-related services (e.g., neurologists);

3. dementia-specific training requirements for public and private employees who interact with people living with Alzheimer's or dementia (e.g., long-term care providers and first responders);

4. home and community-based services, including respite care;

5. quality of care measures for home and community-based services and residential care facilities; and

6. state-supported Alzheimer's and dementia research conducted at higher education institutions in Connecticut.

Policies and Strategies. Lastly, the plan must make findings and recommendations about policies and strategies that do the following:

1. increase public awareness of Alzheimer's and dementia;

2. educate health care providers to increase early detection and diagnosis of these diseases;

3. improve health care services for people living with Alzheimer's and dementia;

4. evaluate the health care system's capacity to meet the growing number and needs of people living with Alzheimer's or dementia;

5. increase the number of health care providers available to treat the growing aging population and populations living with Alzheimer's or dementia;

6. improve services provided in the home and community to delay and decrease the need for institutionalized care for people living with these diseases;

7. improve long-term care services, including assisted living services for people living with Alzheimer's or dementia;

8. assist unpaid Alzheimer's and dementia caregivers;

9. increase and improve research on Alzheimer's and dementia;

10. promote activities to maintain and improve brain health;

11. improve data and information collection relating to Alzheimer's, dementia, and the public health burdens associated with these diseases;

12. improve public safety and address the safety-related needs of people living with Alzheimer's or dementia;

13. address legal protections for, and legal issues faced by, people living with these diseases; and

14. improve ways the state evaluates and adopts policies to assist people living with Alzheimer's or dementia.

Task Force Composition

Under the bill, the task force consists of 15 members, 11 of whom the governor must appoint. The 11 appointees must include the following:

1. a person living with early-stage or early-onset Alzheimer's or dementia;

2. a family caregiver of a person living with Alzheimer's or dementia;

3. a representative from a municipality that provides services to senior citizens;

4. a person representing home health care agencies;

5. two health care providers with experience diagnosing and treating Alzheimer's disease;

6. a person representing a national organization that advocates for people living with Alzheimer's or dementia;

7. a person representing the area agencies on aging;

8. a person representing long-term care facilities;

9. an expert in aging policy issues; and

10. a person representing homemaker-companion agencies.

The task force must also include the state ombudsman and the aging and disability services, public health, and social services commissioners, or their designees.

All initial task force appointments must be made by January 1, 2026,

and those initially appointed serve either a two- or three-year term as specified in the bill. Subsequent appointees must serve two-year terms. Members may be reappointed for an additional two-year term.

Task Force Organization

The aging and disability services commissioner, or her designee, must convene the first task force meeting within 30 days after all members are appointed. Task force members must select a chairperson and vice chairperson, from among the task force's members, to serve in those roles for up to two consecutive years. The task force must meet at least quarterly.

The Aging Committee's administrative staff serves as the task force's administrative staff.

Background — Related Bill

sHB 6912 (File 111), favorably reported by the Aging Committee, similarly establishes an Alzheimer's Disease and Dementia Task Force and requires the task force to develop a State Alzheimer's Plan.

§ 3 — TRANSFERS AND DISCHARGES IN RESIDENTIAL CARE HOMES

Adds to the information that residential care homes must include in the notice to residents before an involuntary transfer or discharge; requires these facilities to consider a resident's closeness to family and known support networks when helping residents find an alternative residence

Under existing law, if a residential care home involuntarily transfers or discharges a resident, the facility must give written notice to the resident and (if known) the resident's legally liable relative, guardian, or conservator. The facility must send the notice at least 30 days in advance except in an emergency.

The bill requires the written notice to include (1) the location to which the resident is being transferred or discharged and (2) an attestation by the facility that the notice was submitted to the Long-Term Care Ombudsman's website portal the same day it was given to the resident.

Under the bill, if the information in the written notice changes before

the transfer or discharge of the resident, the facility must update the notice as soon as practically possible.

The bill also requires residential care homes to consider a resident's proximity to family and known support networks when, as required by existing law, they help residents find a new appropriate placement when leaving or being transferred from the facility.

Appeals to Transfer or Discharge Decisions

Under existing law, a resident, or their legally liable relative, guardian, or conservator who has been notified by a facility that the resident will be transferred or discharged, may appeal the decision by filing a hearing request with the Department of Public Health commissioner within 10 days after the notice.

Under the bill, if the facility updates the location of where the resident will be transferred or discharged, any of these people may appeal the decision within 10 days after the updated notice. During those 10 days, the resident may not be involuntarily transferred or discharged to any location.

Background — Related Bill

HB 6972 (File 115), favorably reported by the Aging Committee, similarly adds to the information that residential care homes must include in their written notice before an involuntarily discharge or transfer and requires the notice to be updated as soon as practical if the information changes.

§§ 4 & 5 — HEALTH INSURANCE COVERAGE FOR BIOMARKER TESTING

Requires certain individual and group health insurance policies to cover biomarker testing to diagnose, treat, manage, or monitor an insured's disease or condition

The bill requires certain individual (§ 4) and group health insurance policies (§ 5) to cover biomarker testing to diagnose, treat, manage, or monitor an insured's disease or condition, if medical and scientific evidence (e.g., federal Food and Drug Administration approval, Medicare coverage determinations, or nationally recognized clinical

guidelines) shows the testing has clinical utility. The policies must provide coverage in a way that limits any disruptions to the insured's care. However, the policies may require that biomarker testing be done at an in-network clinical laboratory.

The bill also (1) requires health carriers to establish a process for insureds to request an exception to a coverage policy or dispute an adverse utilization review determination (e.g., denial) related to the coverage and (2) sets specific requirements for prior authorization requests.

Under the bill, a "biomarker" is a physical characteristic, including a gene mutation or protein expression that can be objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention for a disease or condition. "Biomarker testing" is the analysis of a patient's tissue, blood, or other biospecimen for a biomarker. Biomarker testing does not include an analysis of how a patient physically functions or feels.

EFFECTIVE DATE: January 1, 2026

Process for Policy Exceptions and Coverage Appeals

The bill requires each health carrier (e.g., insurer or HMO) to establish a clear, readily accessible, and convenient process through which an insured, or his or her health care provider, may request a coverage policy exception or dispute an adverse utilization review determination. Carriers must post these processes on their websites.

Prior Authorization Requests

Under the bill, if the health insurance policy requires an insured to receive prior authorization for biomarker testing, the health carrier, associated utilization review entity, or third party acting on the carrier's behalf must approve or deny the prior authorization request within specified deadlines. Specifically, it must notify the insured, his or her health care provider, or any entity requesting the prior authorization of

the approval or denial (1) within seven days, if the prior authorization is not urgent, or (2) within 72 hours if it is urgent. Under the bill, the health care provider determines if the authorization is urgent or not.

Bill Applicability

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

§ 6 — TUITION WAIVERS FOR NURSING HOME RESIDENTS

Generally requires the Board of Trustees of the Community-Technical Colleges to waive tuition fees at any of the regional community-technical colleges for residents who, regardless of age, reside in a nursing home for at least 30 days

The bill generally requires the Board of Trustees of the Community-Technical Colleges to waive tuition fees at any of the regional community-technical colleges for nursing home residents, regardless of age, who enroll in any course at these colleges. To qualify, nursing home residents must be a resident of the facility for at least 30 days. In addition, there must be enough other students enrolled in the course to offer it, and space available in the course after accommodating these other students.

Under existing law, state residents 62 years of age or older are eligible to have their tuition waived at the regional community-technical colleges if there are enough other students and space available after accommodating them.

EFFECTIVE DATE: Upon passage

Background — Related Bill

HB 7006 (File 118), favorably reported by the Aging; Higher Education and Employment Advancement; and Finance, Revenue and Bonding committees, requires the Board of Trustees of the Community-

Technical Colleges to waive tuition fees at any of the regional community-technical colleges for residents who, regardless of age, reside in a nursing home and enroll in online courses.

§ 7 — NURSING HOME TRANSFERS

Requires certain long-term care facilities to consider closeness to support networks when a resident is being transferred from a facility

The bill requires all Medicaid certified nursing facilities, Medicare certified skilled nursing facilities, and nursing homes to consider a resident's proximity to family and known support networks when, as required by existing law, they help residents find a new appropriate placement when leaving or being transferred from the facility.

EFFECTIVE DATE: Upon passage

§ 8 — RESIDENTIAL CARE HOME WORKING GROUP

Establishes a working group to examine topics related to residential care homes

The bill requires the state ombudsman, with the social services and public health commissioners, to convene a working group to examine (1) residential care home evacuation procedures and (2) if residential care homes should be required to use a mutual aid digital platform that supports the risk management needs of health care organizations, which includes dedicated solutions for:

1. emergency management,
2. inspections,
3. testing and maintenance management, and
4. health care coalition and inspections management.

The working group must include at least two people representing residential care homes and submit a report to the Aging, Human Services, and Public Health committees, by January 1, 2026, that contains the group's findings and recommendations.

EFFECTIVE DATE: Upon passage

§ 9 — WAITING LIST EXEMPTION

Adds to the circumstances when nursing homes generally must ignore their waiting list when admitting residents who are transferring from another nursing home

Existing law generally requires Medicaid-certified nursing homes to (1) admit residents on a first-come, first-served basis, regardless of their payment source and (2) keep waiting lists of and admit applicants in the order they are received, with certain exceptions (e.g., under certain conditions, when an applicant directly transfers from a home that is closing).

Under the bill, a nursing home generally must disregard its waiting list and admit an applicant who seeks to transfer from a nursing home that (1) has filed a certificate of need (CON) request (but before the social services commissioner makes a decision) and (2) has five residents or less.

But under the bill, nursing homes are not required to admit these applicants under certain circumstances, such as when the nursing home determines that the applicant does not (1) have a payor source because they have been denied Medicaid eligibility or (2) require a nursing home level of care according to law. The same exceptions apply under existing law for certain other transfers.

COMMITTEE ACTION

Aging Committee

Joint Favorable Substitute
Yea 13 Nay 0 (03/04/2025)

Insurance and Real Estate Committee

Joint Favorable
Yea 11 Nay 2 (04/01/2025)

Appropriations Committee

Joint Favorable
Yea 41 Nay 9 (05/05/2025)