House of Representatives

General Assembly

File No. 423

February Session, 2024

Substitute House Bill No. 5488

House of Representatives, April 10, 2024

The Committee on Public Health reported through REP. MCCARTHY VAHEY of the 133rd Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES.

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

Section 1. Section 19a-6s of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) For purposes of this section, "clinical medical assistant" means a person who (1) (A) is certified by the American Association of Medical Assistants, the National Healthcareer Association, the National Center for Competency Testing, **[**or**]** the American Medical Technologists or the American Medical Certification Association, and (B) has graduated from a postsecondary medical assisting program (i) that is accredited by the Commission on Accreditation of Allied Health Education Programs, the Accrediting Bureau of Health Education Schools or another accrediting organization recognized by the United States Department of Education, or (ii) offered by an institution of higher education accredited by an accrediting organization recognized by the United

States Department of Education and that includes a total of seven hundred twenty hours, including one hundred sixty hours of clinical practice skills, including, but not limited to, administering injections, or (2) has completed relevant medical assistant training provided by any branch of the armed forces of the United States.

(b) A clinical medical assistant may administer a vaccine under the supervision, control and responsibility of a physician licensed pursuant to chapter 370, a physician assistant licensed pursuant to chapter 370 or an advanced practice registered nurse licensed pursuant to chapter 378 to any person in any setting other than a hospital setting. Prior to administering a vaccine, a clinical medical assistant shall complete not less than twenty-four hours of classroom training and not less than eight hours of training in a clinical setting regarding the administration of vaccines. Nothing in this section shall be construed to permit an employer of a physician, a physician assistant or an advanced practice registered nurse to require the physician, physician assistant or advanced practice registered nurse to oversee a clinical medical assistant in the administration of a vaccine without the consent of the physician, physician assistant or advanced practice registered nurse.

(c) On or before January first annually, the Commissioner of Public Health shall obtain from the American Association of Medical Assistants, the National Healthcareer Association, the National Center for Competency Testing, **[**and**]** the American Medical Technologists and the American Medical Certification Association a listing of all state residents maintained on said organizations' registries of certified medical assistants. The commissioner shall make such listings available for public inspection.

Sec. 2. Subsection (b) of section 19a-127n of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(b) On and after October 1, 2023, a hospital or birth center, as such terms are defined in section 19a-490, as amended by this act, or outpatient surgical facility, as defined in section 19a-493b, shall report

adverse events to the Department of Public Health on a form prescribed by the commissioner as follows: (1) A written report and the status of any corrective steps shall be submitted not later than seven days after the date on which the adverse event occurred; and (2) a corrective action plan shall be filed not later than thirty days after the date on which the adverse event occurred. Emergent reports, as defined in the regulations adopted pursuant to subsection (c) of this section, shall be made to the department immediately. Failure to report an adverse event to the department or implement a corrective action plan may result in disciplinary action by the commissioner, pursuant to section 19a-494.

Sec. 3. Section 19a-197a of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) As used in this section, "emergency medical services personnel" means (1) any class of emergency medical technician certified pursuant to sections 20-206*ll* and 20-206mm, including, but not limited to, any advanced emergency medical technician, (2) any paramedic licensed pursuant to sections 20-206*ll* and 20-206mm, and (3) any emergency medical responder certified pursuant to sections 20-206*ll* and 20-206mm.

(b) Any emergency medical services personnel who has been trained, in accordance with national standards recognized by the Commissioner of Public Health, in the administration of (1) epinephrine using automatic prefilled cartridge injectors, similar automatic injectable equipment or prefilled vial and syringe, or (2) glucagon nasal powder, and who functions in accordance with written protocols and the standing orders of a licensed physician serving as an emergency department director **[**may administer, on or before June 30, 2024, and**]** shall administer **[**, on and after July 1, 2024,**]** epinephrine using such injectors, equipment or prefilled vial and syringe or glucagon nasal powder when the use of epinephrine or glucagon is deemed necessary by the emergency medical services personnel for the treatment of a patient. All emergency medical services personnel shall receive such

training from an organization designated by the commissioner.

(c) All licensed or certified ambulances shall be equipped with epinephrine in such injectors, equipment or prefilled vials and syringes and glucagon nasal powder to be administered as described in subsection (b) of this section and in accordance with written protocols and standing orders of a licensed physician serving as an emergency department director.

Sec. 4. Subsection (a) of section 20-195c of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2024*):

(a) Each applicant for licensure as a marital and family therapist shall present to the department satisfactory evidence that such applicant has: (1) Completed a graduate degree program specializing in marital and family therapy offered by a regionally accredited college or university or an accredited postgraduate clinical training program accredited by the Commission on Accreditation for Marriage and Family Therapy Education offered by a regionally accredited institution of higher education; (2) completed a supervised practicum or internship with emphasis in marital and family therapy supervised by the program granting the requisite degree or by an accredited postgraduate clinical training program accredited by the Commission on Accreditation for Marriage and Family Therapy Education and offered by a regionally accredited institution of higher education; (3) completed **[**twelve**]** twenty-four months of relevant postgraduate experience, including (A) a minimum of one thousand hours of direct client contact offering marital and family therapy services subsequent to being awarded a master's degree or doctorate or subsequent to the training year specified in subdivision (2) of this subsection, and (B) one hundred hours of postgraduate clinical supervision provided by a licensed marital and family therapist; and (4) passed an examination prescribed by the department. The fee shall be two hundred dollars for each initial application.

Sec. 5. Subdivision (3) of subsection (l) of section 19a-508c of the 2024

supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(3) Notwithstanding the provisions of subdivisions (1) and (2) of this subsection, in circumstances when an insurance contract that is in effect on July 1, 2016, provides reimbursement for facility fees prohibited under the provisions of subdivision (1) of this subsection, and in circumstances when an insurance contract that is in effect on July 1, 2024, provides reimbursement for facility fees prohibited under the provisions of subdivision (2) of this subsection, a hospital or health system may continue to collect reimbursement from the health insurer for such facility fees until the applicable date of expiration, renewal or amendment of such contract, whichever such date is the earliest. A violation of this subsection shall be considered an unfair trade practice pursuant to chapter 735a.

Sec. 6. Section 20-7f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) For purposes of this section:

(1) "Request payment" includes, but is not limited to, submitting a bill for services not actually owed or submitting for such services an invoice or other communication detailing the cost of the services that is not clearly marked with the phrase "This is not a bill".

(2) "Health care provider" means a person licensed to provide health care services under chapter 368d or 368v, chapters 370 to 373, inclusive, chapters 375 to 383b, inclusive, chapters 384a to 384c, inclusive, or chapter 400j.

(3) "Enrollee" means a person who has contracted for or who participates in a health care plan for such enrollee or such enrollee's eligible dependents.

(4) "Coinsurance, copayment, deductible or other out-of-pocket expense" means the portion of a charge for services covered by a health care plan that, under the plan's terms, it is the obligation of the enrollee

to pay.

(5) "Health care plan" has the same meaning as provided in subsection (a) of section 38a-477aa.

(6) "Health carrier" has the same meaning as provided in subsection (a) of section 38a-477aa.

(7) "Emergency services" has the same meaning as provided in subsection (a) of section 38a-477aa.

(b) It shall be an unfair trade practice in violation of chapter 735a for any health care provider to request payment from an enrollee, other than a coinsurance, copayment, deductible or other out-of-pocket expense, for (1) health care services or a facility fee, as defined in section 19a-508c, as amended by this act, covered under a health care plan, (2) emergency services, or services rendered to an insured at an urgent crisis center, as defined in section 19a-179f, covered under a health care plan and rendered by an out-of-network health care provider, or (3) a surprise bill, as defined in section 38a-477aa.

(c) It shall be an unfair trade practice in violation of chapter 735a for any health care provider to report to a credit reporting agency an enrollee's failure to pay a bill for the services, facility fee or surprise bill as set forth in subsection (b) of this section, when a health carrier has primary responsibility for payment of such services, fees or bills.

Sec. 7. (NEW) (*Effective from passage*) Notwithstanding the provisions of section 3-6c of the general statutes, the Governor may enter into a compact, memorandum of understanding or agreement with any federally recognized Indian tribe located within the geographical boundaries of this state pursuant to which birth and death certificates issued pursuant to chapter 93 of the general statutes concerning a birth or death occurring on land held in trust by the United States for such tribe shall be filed with and issued by the clerk or registrar of vital statistics of such tribe in lieu of being filed with and issued by the registrar of vital statistics of a town or municipality.

Sec. 8. Subsection (b) of section 20-195n of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) An applicant for licensure as a master social worker shall: (1) (A) Hold a master's degree from a social work program (i) accredited by the Council on Social Work Education, or (ii) that is in candidate status for accreditation by said council and offered by an institution of higher education in the state during or after the spring semester of 2024, and prior to the fall semester of 2027, or **[**,**]** (B) if educated outside the United States or its territories, have completed an educational program deemed equivalent by the council; and (2) pass the masters level examination of the Association of Social Work Boards or any other examination prescribed by the commissioner.

Sec. 9. Section 20-252 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) No person shall engage in the occupation of registered hairdresser and cosmetician without having obtained a license from the department. Persons desiring such licenses shall apply in writing on forms furnished by the department. No license shall be issued, except a renewal of a license, to a registered hairdresser and cosmetician unless the applicant has shown to the satisfaction of the department that the applicant has complied with the laws and the regulations administered or adopted by the department. No applicant shall be licensed as a registered hairdresser and cosmetician, except by renewal of a license, until the applicant has made written application to the department, setting forth by affidavit that the applicant has (1) (A) successfully completed the ninth grade, (B) completed a course of not less than fifteen hundred hours of study in a school approved in accordance with the provisions of this chapter or in a school teaching hairdressing and cosmetology under the supervision of the State Board of Education, or, if trained outside of Connecticut, in a school teaching hairdressing and cosmetology whose requirements are equivalent to those of a Connecticut school, and (C) passed a written examination satisfactory

to the department, or (2) if the applicant is an apprentice, (A) successfully completed the eighth grade, (B) completed an apprenticeship approved by the Labor Department and conducted in accordance with sections 31-22m to 31-22u, inclusive, and (C) passed a written examination satisfactory to the Department of Public Health. Examinations required for licensure under this chapter shall be prescribed by the department with the advice and assistance of the board. The department shall establish a passing score for examinations with the advice and assistance of the board which shall be the same as the passing score established in section 20-236.

(b) No person applying for licensure as a hairdresser and cosmetician under this chapter shall be required to submit to a state or national criminal history records check as a prerequisite to licensure.

(c) The commissioner shall notify each applicant who is approved to take a written examination required under subsection (a) of this section that such applicant may be eligible for testing accommodations pursuant to the federal Americans with Disabilities Act, 42 USC 12101 et seq., as amended from time to time, or other accommodations, as determined by the board, which may include the use of a dictionary while taking such examination and additional time within which to take such examination.

Sec. 10. Section 20-12i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) **[**On and after October 1, 2011, prior**]** Prior to engaging in the use of fluoroscopy for guidance of diagnostic and therapeutic procedures, a physician assistant or advanced practice registered nurse shall: (1) Successfully complete a course that includes forty hours of didactic instruction relevant to fluoroscopy which includes, but is not limited to, radiation biology and physics, exposure reduction, equipment operation, image evaluation, quality control and patient considerations; (2) successfully complete a minimum of forty hours of supervised clinical experience that includes a demonstration of patient dose reduction, occupational dose reduction, image recording and quality

control of fluoroscopy equipment; and (3) pass an examination prescribed by the Commissioner of Public Health. Documentation that the physician assistant or advanced practice registered nurse has met the requirements prescribed in this subsection shall be maintained at the employment site of the physician assistant or advanced practice registered nurse and made available to the Department of Public Health upon request.

(b) Notwithstanding the provisions of this section or sections 20-74bb and 20-74ee, nothing shall prohibit a physician assistant who is engaging in the use of fluoroscopy for guidance of diagnostic and therapeutic procedures or positioning and utilizing a mini C-arm in conjunction with fluoroscopic procedures prior to October 1, 2011, from continuing to engage in such procedures, or require the physician assistant to complete the course or supervised clinical experience described in subsection (a) of this section, provided such physician assistant shall pass the examination prescribed by the commissioner on or before September 1, 2012. If a physician assistant does not pass the required examination on or before September 1, 2012, such physician assistant shall not engage in the use of fluoroscopy for guidance of diagnostic and therapeutic procedures or position and utilize a mini C-arm in conjunction with fluoroscopic procedures until such time as such physician assistant meets the requirements of subsection (a) of this section.

Sec. 11. Section 19a-508c of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) As used in this section:

(1) "Affiliated provider" means a provider that is: (A) Employed by a hospital or health system, (B) under a professional services agreement with a hospital or health system that permits such hospital or health system to bill on behalf of such provider, or (C) a clinical faculty member of a medical school, as defined in section 33-182aa, that is affiliated with a hospital or health system in a manner that permits such hospital or

health system to bill on behalf of such clinical faculty member;

(2) "Campus" means: (A) The physical area immediately adjacent to a hospital's main buildings and other areas and structures that are not strictly contiguous to the main buildings but are located within two hundred fifty yards of the main buildings, or (B) any other area that has been determined on an individual case basis by the Centers for Medicare and Medicaid Services to be part of a hospital's campus;

(3) "Facility fee" means any fee charged or billed by a hospital or health system for outpatient services provided in a hospital-based facility that is: (A) Intended to compensate the hospital or health system for the operational expenses of the hospital or health system, and (B) separate and distinct from a professional fee;

(4) "Health care provider" means an individual, entity, corporation, person or organization, whether for-profit or nonprofit, that furnishes, bills or is paid for health care service delivery in the normal course of business, including, but not limited to, a health system, a hospital, a hospital-based facility, a freestanding emergency department and an urgent care center;

(5) "Health system" means: (A) A parent corporation of one or more hospitals and any entity affiliated with such parent corporation through ownership, governance, membership or other means, or (B) a hospital and any entity affiliated with such hospital through ownership, governance, membership or other means;

(6) "Hospital" has the same meaning as provided in section 19a-490, as amended by this act;

(7) "Hospital-based facility" means a facility that is owned or operated, in whole or in part, by a hospital or health system where hospital or professional medical services are provided;

(8) "Medicaid" means the program operated by the Department of Social Services pursuant to section 17b-260 and authorized by Title XIX of the Social Security Act, as amended from time to time;

(9) "Observation" means services furnished by a hospital on the hospital's campus, regardless of length of stay, including use of a bed and periodic monitoring by the hospital's nursing or other staff to evaluate an outpatient's condition or determine the need for admission to the hospital as an inpatient;

(10) "Payer mix" means the proportion of different sources of payment received by a hospital or health system, including, but not limited to, Medicare, Medicaid, other government-provided insurance, private insurance and self-pay patients;

(11) "Professional fee" means any fee charged or billed by a provider for professional medical services provided in a hospital-based facility;

(12) "Provider" means an individual, entity, corporation or health care provider, whether for profit or nonprofit, whose primary purpose is to provide professional medical services; and

(13) "Tagline" means a short statement written in a non-English language that indicates the availability of language assistance services free of charge.

(b) If a hospital or health system charges a facility fee utilizing a current procedural terminology evaluation and management (CPT E/M) code, **[**or**]** assessment and management (CPT A/M) code, injection and infusion (CPT) code or drug administration (CPT) code for outpatient services provided at a hospital-based facility where a professional fee is also expected to be charged, the hospital or health system shall provide the patient with a written notice that includes the following information:

(1) That the hospital-based facility is part of a hospital or health system and that the hospital or health system charges a facility fee that is in addition to and separate from the professional fee charged by the provider;

(2) (A) The amount of the patient's potential financial liability, including any facility fee likely to be charged, and, where professional

medical services are provided by an affiliated provider, any professional fee likely to be charged, or, if the exact type and extent of the professional medical services needed are not known or the terms of a patient's health insurance coverage are not known with reasonable certainty, an estimate of the patient's financial liability based on typical or average charges for visits to the hospital-based facility, including the facility fee, (B) a statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, (C) an explanation that the patient may incur financial liability that is greater than the patient would incur if the professional medical services were not provided by a hospital-based facility, and (D) a telephone number the patient may call for additional information regarding such patient's potential financial liability, including an estimate of the facility fee likely to be charged based on the scheduled professional medical services; and

(3) That a patient covered by a health insurance policy should contact the health insurer for additional information regarding the hospital's or health system's charges and fees, including the patient's potential financial liability, if any, for such charges and fees.

(c) If a hospital or health system charges a facility fee without utilizing a current procedural terminology evaluation and management (CPT E/M) code, assessment and management (CPT A/M) code, injection and infusion (CPT) code or drug administration (CPT) code for outpatient services provided at a hospital-based facility, located outside the hospital campus, the hospital or health system shall provide the patient with a written notice that includes the following information:

(1) That the hospital-based facility is part of a hospital or health system and that the hospital or health system charges a facility fee that may be in addition to and separate from the professional fee charged by a provider;

(2) (A) A statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, (B) an explanation that the patient may incur financial liability

that is greater than the patient would incur if the hospital-based facility was not hospital-based, and (C) a telephone number the patient may call for additional information regarding such patient's potential financial liability, including an estimate of the facility fee likely to be charged based on the scheduled professional medical services; and

(3) That a patient covered by a health insurance policy should contact the health insurer for additional information regarding the hospital's or health system's charges and fees, including the patient's potential financial liability, if any, for such charges and fees.

(d) Each initial billing statement that includes a facility fee shall: (1) Clearly identify the fee as a facility fee that is billed in addition to, or separately from, any professional fee billed by the provider; (2) provide the corresponding Medicare facility fee reimbursement rate for the same service as a comparison or, if there is no corresponding Medicare facility fee for such service, (A) the approximate amount Medicare would have paid the hospital for the facility fee on the billing statement, or (B) the percentage of the hospital's charges that Medicare would have paid the hospital for the facility fee; (3) include a statement that the facility fee is intended to cover the hospital's or health system's operational expenses; (4) inform the patient that the patient's financial liability may have been less if the services had been provided at a facility not owned or operated by the hospital or health system; and (5) include written notice of the patient's right to request a reduction in the facility fee or any other portion of the bill and a telephone number that the patient may use to request such a reduction without regard to whether such patient qualifies for, or is likely to be granted, any reduction. Not later than October 15, 2022, and annually thereafter, each hospital, health system and hospital-based facility shall submit to the Health Systems Planning Unit of the Office of Health Strategy a sample of a billing statement issued by such hospital, health system or hospital-based facility that complies with the provisions of this subsection and which represents the format of billing statements received by patients. Such billing statement shall not contain patient identifying information.

(e) The written notice described in subsections (b) to (d), inclusive, and (h) to (j), inclusive, of this section shall be in plain language and in a form that may be reasonably understood by a patient who does not possess special knowledge regarding hospital or health system facility fee charges. On and after October 1, 2022, such notices shall include tag lines in at least the top fifteen languages spoken in the state indicating that the notice is available in each of those top fifteen languages. The fifteen languages shall be either the languages in the list published by the Department of Health and Human Services in connection with section 1557 of the Patient Protection and Affordable Care Act, P.L. 111-148, or, as determined by the hospital or health system, the top fifteen languages in the geographic area of the hospital-based facility.

(f) (1) For nonemergency care, if a patient's appointment is scheduled to occur ten or more days after the appointment is made, such written notice shall be sent to the patient by first class mail, encrypted electronic mail or a secure patient Internet portal not less than three days after the appointment is made. If an appointment is scheduled to occur less than ten days after the appointment is made or if the patient arrives without an appointment, such notice shall be hand-delivered to the patient when the patient arrives at the hospital-based facility.

(2) For emergency care, such written notice shall be provided to the patient as soon as practicable after the patient is stabilized in accordance with the federal Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd, as amended from time to time, or is determined not to have an emergency medical condition and before the patient leaves the hospital-based facility. If the patient is unconscious, under great duress or for any other reason unable to read the notice and understand and act on his or her rights, the notice shall be provided to the patient's representative as soon as practicable.

(g) Subsections (b) to (f), inclusive, and (l) of this section shall not apply if a patient is insured by Medicare or Medicaid or is receiving services under a workers' compensation plan established to provide medical services pursuant to chapter 568.

(h) A hospital-based facility shall prominently display written notice in locations that are readily accessible to and visible by patients, including patient waiting or appointment check-in areas, stating: (1) That the hospital-based facility is part of a hospital or health system, (2) the name of the hospital or health system, and (3) that if the hospital-based facility charges a facility fee, the patient may incur a financial liability greater than the patient would incur if the hospital-based facility was not hospital-based. On and after October 1, 2022, such notices shall include tag lines in at least the top fifteen languages spoken in the state indicating that the notice is available in each of those top fifteen languages. The fifteen languages shall be either the languages in the list published by the Department of Health and Human Services in connection with section 1557 of the Patient Protection and Affordable Care Act, P.L. 111-148, or, as determined by the hospital or health system, the top fifteen languages in the geographic area of the hospital-based facility. Not later than October 1, 2022, and annually thereafter, each hospital-based facility shall submit a copy of the written notice required by this subsection to the Health Systems Planning Unit of the Office of Health Strategy.

(i) A hospital-based facility shall clearly hold itself out to the public and payers as being hospital-based, including, at a minimum, by stating the name of the hospital or health system in its signage, marketing materials, Internet web sites and stationery.

(j) A hospital-based facility shall, when scheduling services for which a facility fee may be charged, inform the patient (1) that the hospital-based facility is part of a hospital or health system, (2) of the name of the hospital or health system, (3) that the hospital or health system may charge a facility fee in addition to and separate from the professional fee charged by the provider, and (4) of the telephone number the patient may call for additional information regarding such patient's potential financial liability.

(k) (1) If any transaction described in subsection (c) of section 19a-486i, results in the establishment of a hospital-based facility at which

facility fees may be billed, the hospital or health system, that is the purchaser in such transaction shall, not later than thirty days after such transaction, provide written notice, by first class mail, of the transaction to each patient served within the three years preceding the date of the transaction by the health care facility that has been purchased as part of such transaction.

(2) Such notice shall include the following information:

(A) A statement that the health care facility is now a hospital-based facility and is part of a hospital or health system, the health care facility's full legal and business name and the date of such facility's acquisition by a hospital or health system;

(B) The name, business address and phone number of the hospital or health system that is the purchaser of the health care facility;

(C) A statement that the hospital-based facility bills, or is likely to bill, patients a facility fee that may be in addition to, and separate from, any professional fee billed by a health care provider at the hospital-based facility;

(D) (i) A statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, and (ii) an explanation that the patient may incur financial liability that is greater than the patient would incur if the hospital-based facility were not a hospital-based facility;

(E) The estimated amount or range of amounts the hospital-based facility may bill for a facility fee or an example of the average facility fee billed at such hospital-based facility for the most common services provided at such hospital-based facility; and

(F) A statement that, prior to seeking services at such hospital-based facility, a patient covered by a health insurance policy should contact the patient's health insurer for additional information regarding the hospital-based facility fees, including the patient's potential financial liability, if any, for such fees.

(3) A copy of the written notice provided to patients in accordance with this subsection shall be filed with the Health Systems Planning Unit of the Office of Health Strategy, established under section 19a-612. Said unit shall post a link to such notice on its Internet web site.

(4) A hospital, health system or hospital-based facility shall not collect a facility fee for services provided at a hospital-based facility that is subject to the provisions of this subsection from the date of the transaction until at least thirty days after the written notice required pursuant to this subsection is mailed to the patient or a copy of such notice is filed with the Health Systems Planning Unit of the Office of Health Strategy, whichever is later. A violation of this subsection shall be considered an unfair trade practice pursuant to section 42-110b.

(5) Not later than July 1, 2023, and annually thereafter, each hospital-based facility that was the subject of a transaction, as described in subsection (c) of section 19a-486i, during the preceding calendar year shall report to the Health Systems Planning Unit of the Office of Health Strategy the number of patients served by such hospital-based facility in the preceding three years.

(l) (1) Notwithstanding the provisions of this section, no hospital, health system or hospital-based facility shall collect a facility fee for (A) outpatient health care services that use a current procedural terminology evaluation and management (CPT E/M) code, **[**or**]** assessment and management (CPT A/M) code, injection and infusion (CPT) code or drug administration (CPT) code and are provided at a hospital-based facility located off-site from a hospital campus, or (B) outpatient health care services provided at a hospital-based facility located off-site from a hospital campus received by a patient who is uninsured of more than the Medicare rate.

(2) Notwithstanding the provisions of this section, on and after July 1, 2024, no hospital or health system shall collect a facility fee for outpatient health care services that use a current procedural terminology evaluation and management (CPT E/M) code or assessment and management (CPT A/M) code and are provided on the

hospital campus. The provisions of this subdivision shall not apply to (A) an emergency department located on a hospital campus, or (B) observation stays on a hospital campus and (CPT E/M) and (CPT A/M) codes when billed for the following services: (i) Wound care, (ii) orthopedics, (iii) anticoagulation, (iv) oncology, (v) obstetrics, and (vi) solid organ transplant.

(3) Notwithstanding the provisions of subdivisions (1) and (2) of this subsection, in circumstances when an insurance contract that is in effect on July 1, 2016, provides reimbursement for facility fees prohibited under the provisions of subdivision (1) of this subsection, and in circumstances when an insurance contract that is in effect on July 1, 2024, provides reimbursement for facility fees prohibited under the provisions of subdivision (2) of this subsection, a hospital or health system may continue to collect reimbursement from the health insurer for such facility fees until the applicable date of expiration, renewal or amendment of such contract, whichever such date is the earliest.

(4) The provisions of this subsection shall not apply to a freestanding emergency department. As used in this subdivision, "freestanding emergency department" means a freestanding facility that (A) is structurally separate and distinct from a hospital, (B) provides emergency care, (C) is a department of a hospital licensed under chapter 368v, and (D) has been issued a certificate of need to operate as a freestanding emergency department pursuant to chapter 368z.

(5) (A) On and after July 1, 2024, if the executive director of the Office of Health Strategy receives information and has a reasonable belief, after evaluating such information, that any hospital, health system or hospital-based facility charged facility fees, other than through isolated clerical or electronic billing errors, in violation of any provision of this section, or rule or regulation adopted thereunder, such hospital, health system or hospital-based facility shall be subject to a civil penalty of up to one thousand dollars. The executive director may issue a notice of violation and civil penalty by first class mail or personal service. Such notice shall include: (i) A reference to the section of the general statutes,

rule or section of the regulations of Connecticut state agencies believed or alleged to have been violated; (ii) a short and plain language statement of the matters asserted or charged; (iii) a description of the activity to cease; (iv) a statement of the amount of the civil penalty or penalties that may be imposed; (v) a statement concerning the right to a hearing; and (vi) a statement that such hospital, health system or hospital-based facility may, not later than ten business days after receipt of such notice, make a request for a hearing on the matters asserted.

(B) The hospital, health system or hospital-based facility to whom such notice is provided pursuant to subparagraph (A) of this subdivision may, not later than ten business days after receipt of such notice, make written application to the Office of Health Strategy to request a hearing to demonstrate that such violation did not occur. The failure to make a timely request for a hearing shall result in the issuance of a cease and desist order or civil penalty. All hearings held under this subsection shall be conducted in accordance with the provisions of chapter 54.

(C) Following any hearing before the Office of Health Strategy pursuant to this subdivision, if said office finds, by a preponderance of the evidence, that such hospital, health system or hospital-based facility violated or is violating any provision of this subsection, any rule or regulation adopted thereunder or any order issued by said office, said office shall issue a final cease and desist order in addition to any civil penalty said office imposes.

(m) (1) Each hospital and health system shall report not later than October 1, 2023, and thereafter not later than July 1, 2024, and annually thereafter, to the executive director of the Office of Health Strategy, on a form prescribed by the executive director, concerning facility fees charged or billed during the preceding calendar year. Such report shall include, but need not be limited to, (A) the name and address of each facility owned or operated by the hospital or health system that provides services for which a facility fee is charged or billed, and an indication as to whether each facility is located on or outside of the

hospital or health system campus, (B) the number of patient visits at each such facility for which a facility fee was charged or billed, (C) the number, total amount and range of allowable facility fees paid at each such facility disaggregated by payer mix, (D) for each facility, the total amount of facility fees charged and the total amount of revenue received by the hospital or health system derived from facility fees, (E) the total amount of facility fees charged and the total amount of revenue received by the hospital or health system from all facilities derived from facility fees, (F) a description of the ten procedures or services that generated the greatest amount of facility fee gross revenue, disaggregated by current procedural terminology category (CPT) code for each such procedure or service and, for each such procedure or service, patient volume and the total amount of gross and net revenue received by the hospital or health system derived from facility fees, disaggregated by on-campus and off-campus, and (G) the top ten procedures or services for which facility fees are charged based on patient volume and the gross and net revenue received by the hospital or health system for each such procedure or service, disaggregated by on-campus and off-campus. For purposes of this subsection, "facility" means a hospital-based facility that is located on a hospital campus or outside a hospital campus.

(2) The executive director shall publish the information reported pursuant to subdivision (1) of this subsection, or post a link to such information, on the Internet web site of the Office of Health Strategy.

Sec. 12. Subsection (d) of section 17a-673c of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) The Commissioner of Mental Health and Addiction Services may request a disbursement of funds from the Opioid Settlement Fund established pursuant to section 17a-674c, in whole or in part, <u>for</u> the establishment and administration of the pilot program.

Sec. 13. Subsection (c) of section 17a-674h of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu

thereof (*Effective from passage*):

(c) Not later than January 1, 2024, the Department of Mental Health and Addiction Services, in collaboration with the Department of Public Health, shall use the Opioid Antagonist Bulk Purchase Fund for the provision of opioid antagonists to eligible entities and by emergency medical services personnel to certain members of the public. Emergency medical services personnel shall distribute an opioid antagonist kit containing a personal supply of opioid antagonists and the one-page fact sheet developed by the Connecticut Alcohol and Drug Policy Council pursuant to section 17a-667a regarding the risks of taking an opioid drug, symptoms of opioid use disorder and services available in the state for persons who experience symptoms of or are otherwise affected by opioid use disorder to a patient who (1) is treated by such personnel for an overdose of an opioid drug, (2) displays symptoms to such personnel of opioid use disorder, or (3) is treated at a location where such personnel observes evidence of illicit use of an opioid drug, or to such patient's family member, caregiver or friend who is present at the location. Emergency medical services personnel shall refer the patient or such patient's family member, caregiver or friend to the written instructions regarding the administration of such opioid antagonist, as deemed appropriate by such personnel.

Sec. 14. Subdivision (5) of subsection (a) of section 19a-77 of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(5) **[**"Year-round" program**]** "Year-round program" means a program open at least fifty weeks per year.

Sec. 15. Subsection (q) of section 19a-89e of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(q) The Commissioner of Public Health may order an audit of the nurse staffing assignments of each hospital to determine compliance with the nurse staffing assignments for each hospital unit set forth in the

nurse staffing plan developed pursuant to subsections (d) and (e) of this section. Such audit may include an assessment of the hospital's compliance with the requirements of this section for the content of such plan, accuracy of reports submitted to the department and the membership of the hospital staffing committee. In determining whether to order an audit, the commissioner shall consider whether there has been consistent noncompliance by the hospital with the nurse staffing plan, fear of false reporting by the hospital **[**,**]** or any other health care quality safety concerns. The hospital that is subject to the audit shall pay the cost of the audit. The audit shall not affect the conduct by the hospital of peer review as defined in section 19a-17b.

Sec. 16. Subsection (a) of section 19a-133c of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section, "structural racism" means a system that structures opportunity and assigns value in a way that disproportionally and negatively impacts Black, Indigenous, Latino or Asian people or other people of color, and "state agency" has the same meaning as provided in section 1-79. The Commission on Racial Equity in Public Health, established under section 19a-133a, shall recommend best practices for state agencies to (1) evaluate structural racism within their own policies, practices **[**,**]** and operations, and (2) create and implement a plan, which includes the establishment of benchmarks for improvement, to ultimately eliminate any such structural racism within the agency.

Sec. 17. Subdivision (1) of subsection (k) of section 19a-508c of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(k) (1) If any transaction described in subsection (c) of section 19a-486i **[**,**]** results in the establishment of a hospital-based facility at which facility fees may be billed, the hospital or health system, that is the purchaser in such transaction shall, not later than thirty days after such transaction, provide written notice, by first class mail, of the transaction

to each patient served within the three years preceding the date of the transaction by the health care facility that has been purchased as part of such transaction.

Sec. 18. Subdivision (21) of section 20-73e of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(21) "Rule" means a regulation, principle **[**,**]** or directive promulgated by the commission that has the force of law; and

Sec. 19. Subparagraph (B) of subdivision (2) of subsection (b) of section 20-87a of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(B) An advanced practice registered nurse having been issued a license pursuant to subsection (d) of section 20-94a who collaborated, prior to the issuance of such license, with a physician licensed to practice medicine in another state may count the time of such collaboration toward the three-year requirement set forth in subparagraph (A) of this **[**subsection**]** subdivision, provided such collaboration otherwise satisfies the requirements set forth in said subparagraph.

Sec. 20. Subsection (d) of section 20-185aa of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) Any health care facility that employs or retains a surgical technologist shall submit to the Department of Public Health, upon request of the department, documentation **[**demonstration**]** demonstrating that the surgical technologist is in compliance with the requirements set forth in this section.

Sec. 21. Subsection (b) of section 38a-479jjj of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) On and after January 1, 2024, a contract entered into between a

pharmacy [benefit] benefits manager and a 340B covered entity shall not contain any of the following provisions:

(1) A reimbursement rate for a prescription drug that is less than the reimbursement rate paid to pharmacies that are not 340B covered entities;

(2) A fee or adjustment that is not imposed on providers or pharmacies that are not 340B covered entities;

(3) A fee or adjustment amount that exceeds the fee or adjustment amount imposed on providers or pharmacies that are not 340B covered entities;

(4) Any provision that prevents or interferes with a patient's choice to receive a prescription drug from a 340B covered entity, including the administration of the drug; and

(5) Any provision that excludes a 340B covered entity from pharmacy [benefit] benefits manager networks based on the 340B covered entity's participation in the federal 340B Drug Pricing Program.

Sec. 22. Subsection (d) of section 38a-518v of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) Nothing in this section shall prohibit or limit a health insurer, health care center, hospital service corporation, medical service corporation or other entity from conducting utilization review for an in-home hospice [services] service, provided such utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for the same hospice services provided in a hospital.

Sec. 23. Subsection (c) of section 10-532 of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(c) When developing the program, said commissioners and executive director **[**,**]** shall (1) consult with insurers that offer health benefit plans in the state, hospitals, local public health authorities, existing early childhood home visiting programs, community-based organizations and social service providers; and (2) maximize the use of available federal funding.

Sec. 24. Subsection (g) of section 19a-59j of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(g) Notwithstanding any provision of the general statutes, the commissioner, or the commissioner's designee, may provide the infant mortality review committee, established pursuant to section 19a-59k, with information as is necessary, in the commissioner's discretion, for the committee to make recommendations regarding the prevention of infant deaths.

Sec. 25. Subdivision (3) of section 19a-111b of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(3) The commissioner shall establish a program for the detection of sources of lead poisoning. Within available appropriations, such program shall include the identification of dwellings in which paint, plaster or other accessible substances contain toxic levels of lead and the inspection of areas surrounding such dwellings for lead-containing materials. Any person who detects a toxic level of lead, as defined by the commissioner, shall report such findings to the commissioner. The commissioner shall inform all interested parties, including, but not limited to, the owner of the building, the occupants of the building, enforcement officials and other necessary parties.

Sec. 26. Subsection (l) of section 19a-490 of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(l) "Assisted living services agency" means an agency that provides chronic and stable individuals with services that include, but need not be limited to, nursing services and assistance with activities of daily living and may have a dementia special care unit or program as defined in section 19a-562;

Sec. 27. Subdivisions (2) and (3) of subsection (b) of section 19a-181 of the 2024 supplement to the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(2) Each authorized emergency medical **[**service**]** services vehicle shall be equipped with the equipment required for its specific vehicle classification as specified in the 2022 Connecticut EMS Minimum Equipment Checklist, as amended from time to time; and

(3) Each authorized emergency medical **[**service**]** services vehicle shall comply with all state and federal safety, design and equipment requirements.

Sec. 28. Subdivision (9) of subsection (c) of section 19a-493 of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(9) The provisions of this subsection shall not apply in the event of a change of ownership or beneficial ownership of ten per cent or less of the ownership of a licensed outpatient surgical facility, as defined in section 19a-493b, resulting in a transfer to a physician licensed under chapter 370 if such facility provides information, in a form and manner prescribed by the commissioner, to update such facility's licensing information.

Sec. 29. Subdivision (2) of subsection (c) of section 19a-566 of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(2) If a patient receiving birth center services no longer presents with a low-risk pregnancy, as defined in section 19a-490, as amended by this act, or otherwise fails to meet the patient eligibility criteria described in

subparagraph (A) of subdivision (1) of this subsection, the birth center providing such services shall ensure the patient's care is transferred to a licensed health care provider capable of providing the appropriate level of obstetrical care for the patient.

Sec. 30. (*Effective from passage*) The Commissioner of Public Health shall conduct a scope of practice review pursuant to sections 19a-16d to 19a-16f, inclusive, of the general statutes, to determine whether naturopathic physicians licensed pursuant to chapter 373 of the general statutes should be permitted to prescribe, dispense and administer prescription medication and, if so, whether the Department of Public Health should (1) establish educational and examination requirements or other qualifications to permit a naturopathic physician to prescribe, dispense and administer prescription medication, or (2) develop a naturopathic formulary of prescription medication that a naturopathic physician who meets such educational and examination requirements or other qualifications may use. Not later than January 1, 2025, the commissioner shall report, in accordance with the provisions of section 11-4a of the general statutes, the findings of such review and any recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	19a-6s
Sec. 2	*October 1, 2024*	19a-127n(b)
Sec. 3	*October 1, 2024*	19a-197a
Sec. 4	*July 1, 2024*	20-195c(a)
Sec. 5	*October 1, 2024*	19a-508c(l)(3)
Sec. 6	*October 1, 2024*	20-7f
Sec. 7	*from passage*	New section
Sec. 8	*from passage*	20-195n(b)
Sec. 9	*October 1, 2024*	20-252
Sec. 10	*October 1, 2024*	20-12i
Sec. 11	*October 1, 2024*	19a-508c
Sec. 12	*from passage*	17a-673c(d)
Sec. 13	*from passage*	17a-674h(c)

Sec. 14	*from passage*	19a-77(a)(5)
Sec. 15	*from passage*	19a-89e(q)
Sec. 16	*from passage*	19a-133c(a)
Sec. 17	*from passage*	19a-508c(k)(1)
Sec. 18	*from passage*	20-73e(21)
Sec. 19	*from passage*	20-87a(b)(2)(B)
Sec. 20	*from passage*	20-185aa(d)
Sec. 21	*from passage*	38a-479jjj(b)
Sec. 22	*from passage*	38a-518v(d)
Sec. 23	*October 1, 2024*	10-532(c)
Sec. 24	*October 1, 2024*	19a-59j(g)
Sec. 25	*October 1, 2024*	19a-111b(3)
Sec. 26	*October 1, 2024*	19a-490(l)
Sec. 27	*October 1, 2024*	19a-181(b)(2) and (3)
Sec. 28	*October 1, 2024*	19a-493(c)(9)
Sec. 29	*October 1, 2024*	19a-566(c)(2)
Sec. 30	*from passage*	New section

PH *Joint Favorable Subst.*

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 25 $	FY 26 $
UConn; UConn Health Ctr.	GF - Cost	See Below	See Below

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 25 $	FY 26 $
Various Municipalities	STATE MANDATE[1] - Cost	See Below	See Below

Explanation

The bill makes various changes to the public health statutes and results in the following fiscal impact.

Section 3 results in annual costs beginning in FY 25 to the University of Connecticut (UConn), the University of Connecticut Health Center, and various municipalities. It requires ambulances to carry glucagon nasal powder for emergency medical services, affecting some municipalities[2] as well as UConn and UConn Health, which both own ambulances. Glucagon nasal powder has an approximate per unit cost of $300 and will need to be replaced about every 18 months unless

[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.

[2]Less than 40% of municipalities own ambulances, with most towns being serviced by non-profit ambulance agencies.

administered sooner.[3]

This section is not anticipated to result in a cost to municipal police departments, even though many police officers are certified emergency medical responders (EMR). The bill does not specify that EMRs or their vehicles need to be equipped with glucagon nasal powder.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to the shelf-life and usage of glucagon nasal powder and inflation.

[3]These costs may not be fully recouped through ambulance billing, as such billing rates are set by the Department of Public Health and are not typically itemized.

OLR Bill Analysis

sHB 5488

AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES.

TABLE OF CONTENTS:

SUMMARY

§ 1 — MEDICAL ASSISTANTS
Adds to the list of organizations from whom a clinical medical assistant may be certified for purposes of qualifying to administer vaccines in non-hospital settings

§ 2 — ADVERSE EVENT REPORTING
Allows DPH to impose disciplinary action on a hospital, birth center, or outpatient surgical facility that fails to report an adverse event

§ 3 — EMS ADMINISTRATION OF GLUCAGON NASAL POWDER
Requires ambulances to be equipped with glucagon nasal powder, and under certain conditions, EMS personnel to administer it to patients

§ 4 — MARITAL AND FAMILY THERAPIST LICENSURE
Increases, from 12 to 24 months, the duration of the postgraduate experience generally required for MFT licensure

§§ 5 & 11 — FACILITY FEES
Reinstates a provision making it an unfair trade practice for a hospital, health system, or hospital-based facility to violate facility fee limits; adds injection and infusion and drug administration to the list of outpatient procedures for which these entities generally cannot collect facility fees, and makes related changes to notice requirements

§ 6 — LIMITS ON BALANCE BILLING AND CREDIT REPORTING
Makes it an unfair trade practice for EMS organizations or health care institutions to (1) request payments (other than out-of-pocket expenses, such as copayments) in certain situations, such as for

covered facility fees, or (2) report to a credit reporting agency if the patient fails to pay for these services

§ 7 — STATE-TRIBAL AGREEMENT ON VITAL RECORDS FILING

Allows the governor to enter into an agreement with the state's federally recognized tribes to allow birth and death certificates to be issued by, and filed with, the tribe instead of the municipality

§ 8 — MASTER SOCIAL WORKER LICENSURE

Allows a master social worker licensure candidate's degree to be from a program that is in the process of getting accredited, before the fall 2027 semester

§ 9 — HAIRDRESSER AND COSMETICIAN LICENSURE TESTING ACCOMMODATIONS

Requires the DPH commissioner to notify hairdresser and cosmetician licensure applicants that they may be eligible for certain testing accommodations

§ 10 — FLUOROSCOPY BY ADVANCED PRACTICE REGISTERED NURSES

Allows APRNs meeting certain requirements to use fluoroscopy for diagnostic and therapeutic procedures

§§ 12-29 — TECHNICAL CHANGES

Makes technical changes in various statutes

§ 30 — NATUROPATH SCOPE OF PRACTICE COMMITTEE

Requires DPH to conduct a scope of practice review on whether naturopathic physicians should be allowed to prescribe, dispense, and administer prescription medication and if so, whether DPH should establish qualifications for this or develop a naturopathic formulary

SUMMARY

This bill makes various substantive, minor, and technical changes in public health-related statutes and programs.

EFFECTIVE DATE: Various; see below.

§ 1 — MEDICAL ASSISTANTS

Adds to the list of organizations from whom a clinical medical assistant may be certified for purposes of qualifying to administer vaccines in non-hospital settings

By law, clinical medical assistants meeting specified certification, education, training, and supervision requirements may administer vaccines in any setting other than a hospital.

The bill adds the American Medical Certification Association (AMCA) to the list of organizations from whom a clinical medical assistant may be certified for this purpose. It makes a corresponding change by adding the AMCA to the list of organizations from whom the Department of Public Health (DPH) must annually obtain a list of state residents certified as medical assistants.

Under existing law, to qualify to administer vaccines, medical assistants may also be certified by the American Association of Medical Assistants, National Healthcareer Association, National Center for Competency Testing, or American Medical Technologists.

EFFECTIVE DATE: Upon passage

§ 2 — ADVERSE EVENT REPORTING

Allows DPH to impose disciplinary action on a hospital, birth center, or outpatient surgical facility that fails to report an adverse event

By law, hospitals, birth centers, and outpatient surgical facilities must report adverse events to DPH in a specified format and generally within seven days after the event. The bill allows DPH to impose disciplinary action if any of these institutions fail to report. By law, these actions include, among other things, revoking or suspending a license, issuing a letter of reprimand, or placing the licensee on probationary status. DPH may only impose this discipline after a hearing.

Existing law already allows DPH to impose these actions if any of these institutions, after an adverse event, fails to implement a corrective action plan as required.

EFFECTIVE DATE: October 1, 2024

Background — Adverse Events

By law, an adverse event is any event that is identified on the National Quality Forum's (NQF) "List of Serious Reportable Events" or

on a list compiled by DPH (CGS § 19a-127n(a)). NQF's list includes 29 events in seven categories (e.g., surgical or invasive procedure events).

§ 3 — EMS ADMINISTRATION OF GLUCAGON NASAL POWDER

Requires ambulances to be equipped with glucagon nasal powder, and under certain conditions, EMS personnel to administer it to patients

The bill requires licensed or certified ambulances to have glucagon nasal powder for emergency medical services (EMS) personnel to administer. (Glucagon nasal powder is used to treat severely low blood sugar in people with diabetes.)

Specifically, it requires EMS personnel to administer glucagon nasal powder when each of the following conditions are met:

1. the EMS professional has been trained to do so under DPH-recognized national standards,

2. the medication is administered according to written protocols and standing orders of a physician serving as an emergency department director, and

3. the EMS professional determines that administering the medication is necessary to treat the person.

The bill requires all EMS personnel to receive this training from a DPH-designated organization. Under the bill, "EMS personnel" include emergency medical technicians (EMTs), including advanced EMTs; paramedics; and emergency medical responders.

EFFECTIVE DATE: October 1, 2024

§ 4 — MARITAL AND FAMILY THERAPIST LICENSURE

Increases, from 12 to 24 months, the duration of the postgraduate experience generally required for MFT licensure

The bill increases, from 12 to 24 months, the duration of the postgraduate experience generally required for initial licensure as a marital and family therapist (MFT). (This change generally corresponds to a recent change in federal law allowing MFTs who meet certain

criteria to bill Medicare independently for their mental health services.)

Under existing law, this postgraduate experience must include at least (1) 1,000 hours of direct client contact meeting certain requirements and (2) 100 hours of postgraduate clinical supervision by an MFT.

EFFECTIVE DATE: July 1, 2024

§§ 5 & 11 — FACILITY FEES

Reinstates a provision making it an unfair trade practice for a hospital, health system, or hospital-based facility to violate facility fee limits; adds injection and infusion and drug administration to the list of outpatient procedures for which these entities generally cannot collect facility fees, and makes related changes to notice requirements

Existing law limits when hospitals, health systems, and hospital-based facilities may charge facility fees for outpatient services provided off-site from a hospital campus. Starting July 1, 2024, the law also prohibits hospitals or health systems from charging facility fees for certain on-campus outpatient procedures that are not performed in the emergency department.

The bill reinstates a provision, repealed by PA 23-171, making it an unfair trade practice (see *Background — Connecticut Unfair Trade Practices Act (CUTPA)*) to violate facility fee limits. Starting July 1, 2024, PA 23-171 also allows the Office of Health Strategy to impose civil penalties of up to $1,000 for certain violations of these limits.

Among other limits on off-site outpatient services, existing law generally prohibits hospitals, health systems, and hospital-based facilities from charging facility fees for these services that use a current procedural terminology evaluation and management (CPT E/M) code or CPT assessment and management (CPT A/M) code. The bill additionally prohibits them from charging facility fees for injection and infusion or drug administration CPT codes at these locations. As under existing law, these limits do not apply to Medicare and Medicaid patients, patients receiving services under a workers' compensation plan, or freestanding emergency departments.

The bill also adds these new codes to the list of codes for which

facility fee notices must include more information than is otherwise required.

By law, a "facility fee" is any fee a hospital or health system charges or bills for outpatient hospital services provided in a hospital-based facility that is (1) intended to compensate the hospital or health system for its operational expenses and (2) separate and distinct from the provider's professional fee.

EFFECTIVE DATE: October 1, 2024

Patient Notification Requirements (§ 11(b) & (c))

Under existing law, hospitals or health systems that charge facility fees must give patients receiving outpatient services written notice about their potential financial liability. The notice must include additional information when the hospital or health system (1) uses CPT E/M or A/M codes for these services and (2) expects to charge a separate fee for professional medical services. The bill also applies the additional notice requirements if the hospital or health system uses injection and infusion or drug administration CPT codes in these situations. (As noted above, under the bill, these fees are generally prohibited at off-campus facilities.)

Generally, the notice must include, among other things, (1) the amount of the patient's potential financial liability or (2) an estimate, based on the facility's typical or average charges, if the exact type and extent of services are unknown or the terms of the patient's insurance coverage are not known with reasonable certainty.

As under existing law, these notice requirements do not apply to Medicare or Medicaid patients or patients receiving services under a workers' compensation plan.

Background — Connecticut Unfair Trade Practices Act (CUTPA)

The law prohibits businesses from engaging in unfair and deceptive acts or practices. CUTPA allows the Department of Consumer Protection (DCP) commissioner to issue regulations defining what

constitutes an unfair trade practice, investigate complaints, issue cease and desist orders, order restitution in cases involving less than $10,000, enter into consent agreements, ask the attorney general to seek injunctive relief, and accept voluntary statements of compliance. It also allows individuals to sue. Courts may issue restraining orders; award actual and punitive damages, costs, and reasonable attorney's fees; and impose civil penalties of up to $5,000 for willful violations and $25,000 for violation of a restraining order.

Background — Related Bill

sHB 5236 (File 103), § 25, favorably reported by the General Law Committee, among other things, allows DCP to impose a civil penalty of up to $5,000 for CUTPA violations, after an administrative hearing.

§ 6 — LIMITS ON BALANCE BILLING AND CREDIT REPORTING

Makes it an unfair trade practice for EMS organizations or health care institutions to (1) request payments (other than out-of-pocket expenses, such as copayments) in certain situations, such as for covered facility fees, or (2) report to a credit reporting agency if the patient fails to pay for these services

The bill makes it a CUTPA violation for a licensed EMS organization or health care institution to "balance bill" an insured (i.e., bill more than the collectable cost-sharing under the policy) for the following:

1. covered health care services or facilities fees, or

2. covered emergency services, or services at a Department of Children and Families (DCF)-licensed urgent crisis center, provided by an out-of-network provider.

The bill also makes it a CUTPA violation for licensed EMS organizations or health care institutions to bill an insured for a surprise bill (see *Background — Surprise Bills*), other than collectable cost-sharing.

Finally, it makes it a CUTPA violation for these organizations or institutions to report to a credit reporting agency when an enrollee fails to pay for any of the above when a health carrier (e.g., insurer or HMO) has primary responsibility for paying.

Under existing law, these restrictions already apply to most health care providers.

EFFECTIVE DATE: October 1, 2024

Background — Surprise Bills

Generally, a "surprise bill" is a bill for health care services (other than emergency services or DCF-licensed crisis center services) received by an insured for services by an out-of-network provider at an in-network facility during a service or procedure that was performed by an in-network provider or previously approved by the health carrier, if the insured did not knowingly elect to receive the services from the out-of-network provider (CGS § 38a-477aa).

§ 7 — STATE-TRIBAL AGREEMENT ON VITAL RECORDS FILING

Allows the governor to enter into an agreement with the state's federally recognized tribes to allow birth and death certificates to be issued by, and filed with, the tribe instead of the municipality

Existing law requires the governor to submit any compact between the state and an Indian tribe to the legislature for approval or rejection (CGS § 3-6c). Regardless of this provision, the bill allows the governor to enter into a compact, memorandum of understanding, or agreement with any federally recognized tribe in the state over certificates for births or deaths occurring on tribal land. Specifically, they may enter an agreement allowing these certificates to be issued by, and filed with, the tribe's clerk or registrar of vital statistics, instead of the municipality's registrar.

EFFECTIVE DATE: Upon passage

§ 8 — MASTER SOCIAL WORKER LICENSURE

Allows a master social worker licensure candidate's degree to be from a program that is in the process of getting accredited, before the fall 2027 semester

By law, an applicant for a master social worker license must have a master's degree in social work. The bill allows the degree to be from a program that (1) is in the process of getting accredited by the Council on Social Work Education and (2) was offered from the spring 2024 semester and before the fall 2027 semester. Under current law, the

program must already be accredited.

Existing law requires applicants educated outside of the country to have passed an educational program that the council deems equivalent.

EFFECTIVE DATE: Upon passage

§ 9 — HAIRDRESSER AND COSMETICIAN LICENSURE TESTING ACCOMMODATIONS

Requires the DPH commissioner to notify hairdresser and cosmetician licensure applicants that they may be eligible for certain testing accommodations

The bill requires the DPH commissioner to notify hairdresser and cosmetician licensure applicants approved to take the written licensure examination that they may be eligible for testing accommodations under the federal Americans with Disabilities Act or other accommodations determined by the state Examining Board for Barbers, Hairdressers and Cosmeticians. Under the bill, these accommodations may include (1) using a dictionary while taking the licensure examination or (2) additional time to complete it.

EFFECTIVE DATE: October 1, 2024

§ 10 — FLUOROSCOPY BY ADVANCED PRACTICE REGISTERED NURSES

Allows APRNs meeting certain requirements to use fluoroscopy for diagnostic and therapeutic procedures

The bill authorizes advanced practice registered nurses (APRN) to use fluoroscopy to guide diagnostic and treatment procedures if they meet certain training, experience, and examination requirements.

Under the bill, to use fluoroscopy, an APRN must do the following:

1. complete 40 hours of relevant instruction that includes radiation biology and physics, exposure reduction, equipment operation, image evaluation, quality control, and patient considerations;

2. complete 40 hours of supervised clinical experience that includes a demonstration of patient dose reduction, occupational dose reduction, image recording, and equipment quality control; and

3. pass a DPH-prescribed test.

Under the bill, documentation that an APRN has met these requirements must be kept at the APRN's worksite and be available to DPH upon request.

EFFECTIVE DATE: October 1, 2024

§§ 12-29 — TECHNICAL CHANGES

Makes technical changes in various statutes

The bill makes technical changes in various public health-related statutes.

EFFECTIVE DATE: Upon passage (§§ 12-22) or October 1, 2024 (§§ 23-29).

§ 30 — NATUROPATH SCOPE OF PRACTICE COMMITTEE

Requires DPH to conduct a scope of practice review on whether naturopathic physicians should be allowed to prescribe, dispense, and administer prescription medication and if so, whether DPH should establish qualifications for this or develop a naturopathic formulary

The bill requires the DPH commissioner to conduct a scope of practice review, under the existing process for scope of practice review committees, to determine whether (1) naturopathic physicians should be allowed to prescribe, dispense, and administer prescription medication and (2) if so, DPH should establish educational, examination, or other qualifications for this or develop a naturopathic formulary. The commissioner must report the committee's findings and recommendations to the Public Health Committee by January 1, 2025.

Existing law establishes a process to review requests from health care professions seeking to establish or revise a scope of practice prior to consideration by the legislature. Within available appropriations, DPH appoints members to scope of practice review committees. The committees consist of (1) the DPH commissioner or her designee (who serves as the committee chairperson and in a non-voting capacity); (2) two members representing the profession making the request; and (3) two members recommended by each person or entity that submitted a written impact statement to represent the professions directly impacted

by the request. DPH may also appoint additional members representing health care professions with a close relationship to the underlying scope of practice request (CGS § 19a-16e).

EFFECTIVE DATE: Upon passage

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 23 Nay 13 (03/22/2024)