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

# 2026

## REGULAR SESSION OF THE CONNECTICUT GENERAL ASSEMBLY

PREPARED BY:


WIGGIN AND DANA

One Century Tower
New Haven, Connecticut 06508
(203) 498-4400
www.wiggin.com

&

LeadingAge Connecticut & Rhode Island

110 Barnes Road
Wallingford, Connecticut 06492
(203) 678-4477
www.leadingagectri.org

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*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

## TABLE OF ACRONYMS

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|---|---|
| ADS | Connecticut Department of Aging and Disability Services |
| ALSA | Assisted Living Services Agency |
| APRN | Advanced Practice Registered Nurse |
| CCNH | Chronic and Convalescent Nursing Home |
| CDPA | Connecticut Data Privacy Act |
| C.G.S. | Connecticut General Statutes |
| CMS | Centers for Medicare & Medicaid Services |
| CON | Certificate of Need |
| CONNIE | Statewide Health Information Exchange |
| DCP | Connecticut Department of Consumer Protection |
| DDS | Connecticut Department of Developmental Services |
| DMHAS | Connecticut Department of Mental Health and Addiction Services |
| DPH | Connecticut Department of Public Health |
| DSS | Connecticut Department of Social Services |
| FY | Fiscal Year |
| HCA | Homemaker-Companion Agency |
| HIPAA | Health Insurance Portability and Accountability Act |
| HHA | Home Health Aide |
| MRC | Managed Residential Community |
| OHA | Connecticut Office of the Healthcare Advocate |
| OHS | Connecticut Office of Health Strategy |
| OPM | Connecticut Office of Policy Management |
| PCA | Personal Care Assistant |
| RCH | Residential Care Home |
| UAPA | Uniform Administrative Procedure Act |



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

## I. BUDGET/IMPLEMENTER

1. PUBLIC ACT 26-68. AN ACT MAKING ADJUSTMENTS TO THE STATE BUDGET FOR THE BIENNIUM ENDING JUNE 30, 2027, MAKING DEFICIENCY APPROPRIATIONS FOR THE FISCAL YEAR ENDING JUNE 30, 2026, AUTHORIZING AND ADJUSTING BONDS OF THE STATE AND CONCERNING PROVISIONS RELATING TO REVENUE, SCHOOL CONSTRUCTION AND OTHER ITEMS TO IMPLEMENT THE STATE BUDGET.
*Effective July 1, 2026, except as otherwise noted*

**§§ 97–161 — Elimination of the Office of Health Strategy; Transfer of Functions to DPH, OPM, DSS and OHA**

The Act eliminates OHS as a standalone agency effective July 1, 2026, but does not designate a single universal successor. Instead, it transfers discrete OHS functions to different successor agencies depending on the subject matter:

DPH receives all functions relating to the Health Systems Planning Unit (established under C.G.S. § 19a-612), the CON process (C.G.S. §§ 19a-638 to 19a-641), hospital debt collection standards, hospital facility fee reporting and enforcement, patient discharge and ambulatory surgery data collection, and health care facilities utilization studies. DPH assumes authority over all pending and future CON applications filed on or before June 30, 2027, and inherits all existing OHS orders, settlements and regulations concerning these functions.

OPM receives all functions relating to the Statewide Health Information Exchange (CONNIE), the all-payer claims database program (C.G.S. § 19a-755a), health care cost growth benchmarks and health care quality benchmarks (C.G.S. §§ 19a-754f to 19a-754k), and contracts related to the American Rescue Plan Act (ARPA). The Secretary of OPM assumes the responsibilities of the former Commissioner of Health Strategy with respect to the State Health Information Technology Advisory Council and the health information technology plan. OPM's statutory duties (C.G.S. § 4-66) are expanded to include coordination of health information technology initiatives, administration of the all-payer claims database, maintenance of a consumer health information website, designation of a health information technology officer, and health care cost/quality benchmark-setting.

DSS receives hospital financial health reporting by hospitals (C.G.S. § 19a-486j) and assumes responsibility for administering the Covered Connecticut program waiver under Section 1115.

OHA receives community benefit program reporting by hospitals (C.G.S. § 19a-127k), including the annual summary and analysis of community benefit reports.

Each successor agency may implement interim policies and procedures pending formal rulemaking, provided it publishes notice on the eRegulations System within twenty (20) days.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

Existing OHS orders, decisions, agreed settlements and regulations continue in force as orders or regulations of the appropriate successor agency until amended, repealed or superseded. Statutory references to the OHS or Commissioner of Health Strategy are deemed to refer to the appropriate successor agency or official for the transferred function involved.

**§§ 183–185, as amended by Public Act 26-76 §§ 77–78 — DPH Enforcement Authority and Penalties for Unlicensed Operations and Services**
*Effective October 1, 2026*

***Section 183 — Criminal and Civil Penalties for Operating Without Required Institutional Licensure or Nursing Facility Management Services Certification.***

Existing law imposed a fine of up to $100 per offense on a person who established, conducted, managed or operated an institution without the license required under C.G.S. §§ 19a-490 to 19a-503, or who owned real property or improvements where such an unlicensed institution was established, conducted, managed or operated. Each day of a continuing violation after conviction was treated as a separate offense.

Section 183, as originally enacted in Public Act 26-68, would have made it a class D felony to establish, conduct, manage or operate an institution without a license required under DPH's institutional licensure chapter, or to provide nursing facility management services without the certificate required under C.G.S. § 19a-561. Public Act 26-76 § 77 later revised that penalty before the October 1, 2026 effective date. As amended, the violation is a class C misdemeanor, not a class D felony, and the daily fine is reduced from up to $5,000 per day to up to $2,000 per day for each day of continuing action in violation of the licensure or nursing facility management services certification requirements.

Section 183 provides a lower penalty for owners of real property or improvements where an institution is established, conducted, managed or operated without the required license under DPH's institutional licensure chapter or without the nursing facility management services certificate required under C.G.S. § 19a-561. The owners may be fined up to $100 for each offense, with each day of a continuing violation after conviction treated as a separate offense.

The exception in the existing statute for financial institutions that acquire title through mortgage foreclosure while an operator continues to occupy the property remains in effect and an additional exception was added for institutions that apply to renew a lapsed license within sixty (60) days, even if the renewal application is incomplete when filed.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

***Section 184, as amended by Public Act 26-76 § 78 — Injunctions and Administrative Civil Penalties for Unlicensed Operations.***

Section 184 strengthens DPH's civil enforcement tools by authorizing DPH, upon the advice of the Attorney General, to investigate and bring an action in the name of the state for an injunction or other court process to restrain or prevent the establishment, conduct, management or operation of an institution or nursing facility management services without the required license or certificate under DPH's institutional licensure chapter. Public Act 26-68 originally authorized DPH, after a UAPA hearing, to impose a civil penalty of up to $25,000 per day for operating without the required license or certificate. Public Act 26-76 § 78 later reduced that civil penalty amount to up to $5,000 per day. This remedy remains separate from, and in addition to, other available remedies.

***Section 185 — Summary Orders and Penalties for Unlicensed Professional Services.***

Section 185 addresses professional licensure, not institutional licensure. It authorizes any DPH board or commission listed in C.G.S. § 19a-14(b), and DPH itself for professions under its jurisdiction that do not have a board or commission, to issue a summary order requiring the immediate discontinuance of a statutory or regulatory violation that poses an imminent risk to public health, safety or welfare, pending proceedings on whether to issue a cease and desist order. The Section also authorizes the board, commission or DPH, after a UAPA hearing, to impose a civil penalty of up to $25,000 on a person who provides professional services under DPH's jurisdiction without a required license or certificate, with each day of unlicensed services constituting grounds for a separate penalty. The enforcement order may be pursued through the Attorney General in Superior Court.

**§ 192 — Medical Orders for Life-Sustaining Treatment (MOLST) Program Revisions**
*Effective May 26, 2026*

This Section revises Connecticut's MOLST statute to clarify that a "medical order for life-sustaining treatment" is not merely a single written medical order, but a specific set of written medical orders developed by DPH for the MOLST program. Physician assistants were already among the clinicians who could make a MOLST order, but the Act now also recognizes a physician assistant, along with a physician or APRN, as a clinician who may determine that the patient is approaching the end stage of a serious, life-limiting illness or is in a condition of advanced, chronic progressive frailty. Patient participation remains voluntary and must be documented by the signature of the patient or legally authorized representative on the MOLST form.

The Section also changes the documentation requirement after signing. Instead of requiring that the patient or legally authorized representative be given the original order immediately after signing, the amended statute requires that the patient or representative be given a copy of, or access to, the order, and that a copy be immediately placed in the patient's medical record. The Section



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

further adds that a MOLST order is not valid unless completed on a DPH-prescribed form and executed in accordance with the statute and applicable regulations.

**§ 194 — DPH Authority to Resolve Compliance Matters by Agreed Settlement or Consent Order**
*Effective October 1, 2026*

This Section amends C.G.S. § 19a-2a to add express authority for DPH, in administering or enforcing any applicable statute, regulation, permit or order, to resolve compliance disputes or ensure compliance with regulatory requirements through an agreed settlement or consent order. Consent orders resolving petitions filed under C.G.S. § 19a-12e remain subject to approval by the board or commission with jurisdiction over the health care professional.

**§§ 226–246 — New Hospital and Health Care Facility Certificate of Need Framework**
*Effective October 1, 2026*

These Sections create a new CON framework, operative for applications submitted on and after July 1, 2027. CON applications filed on or before June 30, 2027 remain subject to the existing CON process, as transferred from OHS to DPH. (Note that these Sections address the hospital and health care facility CON process administered through DPH, and should be distinguished from the separate DSS approval process for certain long-term care bed additions, relocations and replacement facilities. Importantly, this DPH CON process does not apply to residential care homes, nursing homes/rest homes, assisted living services agencies, home health agencies or hospice services.)

The Act creates a three-member CON decision-making panel consisting of the Commissioner, or designees, of DPH and DSS, along with the Secretary of OPM, with the DPH Commissioner serving as chair. The panel is responsible for final CON decisions and related determinations under the new framework. The Act also creates a CON Program within DPH, overseen by a DPH-designated director, to support application review, prepare reports and monitor compliance.

The new CON requirement continues to apply to specified transactions and service changes, including new health care facilities, changes in ownership or control, certain large group practice transfers, increases in licensed bed capacity, acquisition of certain major imaging equipment, addition of operating rooms, establishment of cardiac services, and certain nonhospital linear accelerator services. However, the Act expressly provides that the CON requirement does not apply to residential care homes, nursing homes/rest homes, assisted living services agencies, home health agencies or hospice services.

The panel must determine whether the applicant has shown, by a preponderance of the evidence, that the proposal is in the public interest, considering factors such as quality of care, access to care,



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

Medicaid access, cost-effectiveness, financial feasibility and stability, public need, and avoidance of unnecessary duplication.

The Act establishes standard and expedited review tracks. The standard process includes filing deadlines, completeness review, public notice, potential public hearing, staff report and final panel decision. The expedited process, available beginning January 1, 2028 for specified categories such as certain relocations, bed increases, imaging equipment acquisitions and limited operating room additions, generally has a shorter decision timeline, but a matter may convert to standard review if intervention is granted.

The Act also addresses certificate validity and nontransferability, enforcement and civil penalties, rulemaking and interim policies, stakeholder input before implementation, and hospital service pauses or terminations, including notice, hearing and access-planning requirements.

**§ 343 — Aging-in-Place Accessibility Modification Grant Program**

This Section creates a new aging-in-place grant program, administered by the Department of Aging and Disability Services in consultation with the Department of Housing. The program will provide grants-in-aid to eligible homeowners to make accessibility modifications that enable them to remain in their primary residences. An "eligible homeowner" is a person who owns and occupies a Connecticut residential property as the person's primary residence, is age 60 or older or a person with a disability and has household income at or below 60% of the area median household income, as determined by the Commissioner of Aging and Disability Services. An "accessibility modification" means a physical alteration to residential property to improve usability, safety and independence for an elderly person or person with a disability. Grants may not exceed $10,000 per eligible homeowner. The Department of Aging and Disability Services must establish the application form and process, criteria for eligible accessibility modifications and grant-award criteria, and may adopt implementing regulations.

**§ 370 — Medicaid Value-Based Payment Working Group**

This Section establishes a Medicaid Value-Based Payment Working Group to collaboratively design, evaluate readiness for, and recommend scalable, voluntary value-based payment models for the Medicaid population. The models are intended to advance quality, cost efficiency, access, health system sustainability and health equity across the health care delivery system. The DSS Commissioner appoints the members, which must include representatives of hospitals, physicians, federally qualified health centers, behavioral health providers, health carriers or managed care organizations participating in Medicaid, consumer advocates and any other stakeholders deemed appropriate by the Commissioner.

The Working Group must evaluate and develop recommendations on voluntary Medicaid value-based payment arrangements, including shared savings models, population-based payment



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

models, quality incentive arrangements and other alternative payment methodologies; strategies to improve quality outcomes, promote access and address health disparities; operational, technological, workforce and infrastructure investments needed to support participation, including up-front funding, technical assistance, data-sharing capabilities and administrative simplification; and opportunities to align Medicaid value-based payment initiatives with state and federal delivery system reform efforts. Any model developed under the Section must be voluntary for participating providers. The Working Group must submit recommendations, including pilot implementation opportunities, to the General Assembly's Joint Committees on Public Health and Human Services by January 1, 2028.

**§§ 445–447, as amended by Public Act 26-76 § 42 — Nursing Home Medicaid Rate Increases, Wage Enhancements, Quality Metrics, Case-Mix Rebase, Utilization Pool and Minimum Occupancy Relief**

*Effective May 26, 2026, except § 447 effective July 1, 2026*

Section 445, as originally enacted in Public Act 26-68, amended the nursing home wage-enhancement provision enacted in Section 332 of Public Act 25-168. Subsequently, Public Act 26-76 § 42 further revised that same wage-enhancement language. As finally amended, DSS must, within available appropriations, increase nursing home facility rates to support wage increases for nursing, nurse's aide, dietary, housekeeping, laundry and maintenance and plant-operation personnel. The wage-supported rate increases remain 3% effective July 1, 2025, 3% effective July 1, 2026, and 4% effective January 1, 2027. However, effective July 1, 2026, the director and assistant director of nursing are not included. Facilities that receive a rate adjustment for wage enhancements but do not provide the enhancements may be subject to a rate decrease in the same amount as the adjustment.

Section 446 revises the quality metrics program. On or after October 1, 2026, DSS may establish payments for high-quality outcomes; beginning FY 2029, DSS shall distribute an annual $10 million pool of enhanced Medicaid quality performance payments based on performance in the quality metrics program. In determining a nursing home facility's maximum quality score points, DSS may use CMS' nursing home quarterly metrics for residents with stays of 101 days or longer, a consumer satisfaction survey and DPH data. Facilities designated by CMS as special focus facilities, special focus facility candidates, or facilities with an abuse icon on CMS Nursing Home Compare are ineligible. The Section also requires DSS, effective July 1, 2026, to utilize the Patient Driven Payment Model (PDPM) nursing component to calculate quarterly case-mix index adjustments, rebasing Medicaid rates using the cost year ending September 30, 2024, with a three-year phase-in. The three-year phase-in period may use phase-in parameters, including budget adjustment factors, case-mix neutrality factors and stop-loss and stop-gain corridors, as necessary to stay within available appropriations. Section 446 also requires DSS, not later than July 1, 2026, to implement a Medicaid utilization pool that provides enhanced Medicaid payments to nursing



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

home facilities with a resident payor mix of more than 75% Medicaid members. DSS must use annual Medicaid cost reports to determine each facility's payor mix and identify eligible facilities each year. The payments are intended to support increased Medicaid utilization and enhanced access and services for Medicaid members. The funding pool is limited to $2.5 million for FY 2027 and $5 million for subsequent fiscal years, and the DSS Commissioner may prorate enhanced Medicaid utilization payments to stay within available appropriations.

Section 447, *effective July 1, 2026*, revises the minimum allowable patient days provision. Notwithstanding the general requirement that utilization of certified beds be determined at a minimum of 90% of capacity, the DSS Commissioner may recalculate the Medicaid rate established for a licensed chronic and convalescent nursing home for the FY ending June 30, 2026, and for each FY thereafter, at any time during the FY to address: (A) temporary licensed bed reductions due to closure of beds during renovations; (B) prolonged workforce staffing challenges; or (C) any other impediments to maintaining full patient census that the Commissioner, in the Commissioner's discretion, determines would justify relief from the minimum allowable patient days requirement.

**§ 450 — Medicaid Rate Study Expansion: Behavioral Health and Home Health**

This Section addresses how DSS must review certain Medicaid reimbursement rates that were included in the Medicaid rate study commissioned under Section 1 of Public Act 23-186. If a service included in that study did not have a corresponding Medicare rate and did not have an average five-state benchmark in the study, DSS must still include that service in its Medicaid rate review. The five-state benchmark group consists of Maine, Massachusetts, New Jersey, New York and Oregon. If only one of those states has a rate for the same or substantially similar service, DSS must use that state's rate for comparison. If two or more of those states have rates for the same or substantially similar service, DSS must use the average of those rates.

The Section also specifically addresses behavioral health-related medication administration provided through home health. For purposes of setting Medicaid reimbursement rates for behavioral health services, DSS must include medication administration services delivered by a licensed home health care agency to individuals with psychiatric diagnoses, when those services are provided under a care plan developed and supervised by a licensed behavioral health clinician or prescriber and overseen by the state's behavioral health administrative services organization. For members, the practical significance is that DSS must account for this home health medication-administration service in behavioral health Medicaid rate-setting, rather than leaving it outside the rate-review framework.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

**§ 451 — Limited Waiver from Two-Bed Room Requirement for Small-House Nursing Facility Development**

This Section adds a limited waiver provision to C.G.S. § 19a-521b. Under existing law, beginning July 1, 2026, a licensed chronic and convalescent nursing home or rest home with nursing supervision may not place a newly admitted resident in a room containing more than two beds. The new language authorizes the DPH Commissioner to waive that requirement for a licensed chronic and convalescent nursing home or rest home with nursing supervision that is actively investing in and developing a new Connecticut small-house style skilled nursing facility to meet the two-bed requirement. The waiver is limited to one licensed chronic and convalescent nursing home or rest home with nursing supervision for each small-house style skilled nursing facility under development. DPH may prescribe documentation requirements for a facility to qualify for the waiver during the transitional period before the new facility opens, and the waiver may not extend beyond July 1, 2027.

## II. ACTS AFFECTING NURSING HOMES, ASSISTED LIVING SERVICES AGENCIES, MANAGED RESIDENTIAL COMMUNITIES, RESIDENTIAL CARE HOMES, HOME HEALTH CARE AGENCIES, HOSPICE AGENCIES AND HOMEMAKER COMPANION AGENCIES

2. PUBLIC ACT 26-3. AN ACT ESTABLISHING CONNECTICUT VACCINE STANDARDS.
*Effective April 27, 2026*

This Act changes the immunization standard applicable to nursing home residents by tying required resident immunizations to Connecticut's "standard of care for immunization" established by DPH, rather than to the prior statutory references to ACIP/HHS recommendations. For nursing homes, the Act amends C.G.S. § 19a-522 to require DPH, in consultation with DSS, to adopt regulations ensuring that each nursing home patient is protected by adequate immunization against respiratory viral diseases, including but not limited to influenza and pneumococcal disease, in accordance with the immunization schedules included in DPH's Connecticut standard of care for immunization. The Act continues to require appropriate exemptions for patients for whom immunization is medically contraindicated and for patients who object on religious grounds.

Pending adoption of formal regulations, DPH may implement interim policies and procedures concerning protection of nursing home patients by adequate immunization against respiratory viral diseases, provided DPH publishes notice of intent to adopt regulations on the eRegulations System within twenty days after implementation. For long-term care providers, the practical significance is that nursing home immunization obligations will be determined by DPH's Connecticut-specific immunization standard and any implementing regulations or interim policies issued under C.G.S. § 19a-522, rather than by direct statutory reference to federal ACIP/HHS recommendations.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

3. PUBLIC ACT 26-103. AN ACT REQUIRING NURSING HOMES TO ANNUALLY REPORT CERTAIN OWNERSHIP INFORMATION REGARDING INVESTMENT ENTITIES, ACQUIRE, IF FEASIBLE, A SURETY BOND OR A SIMILAR FORM OF SECURITY IN AN AMOUNT EQUAL TO NINETY DAYS OF OPERATING COSTS, MAINTAIN FULL GOVERNANCE CONTROL AND AUTHORITY OVER NURSING HOME ASSETS AND ACTIVITIES AND ANNUALLY ATTEST THAT NO INVESTMENT ENTITY HAS CONTROL OVER NURSING HOME RESIDENT HEALTH, SAFETY OR CARE.
*Effective October 1, 2026, unless otherwise noted*

This Act imposes new ownership transparency, financial assurance, and governance requirements on nursing homes that participate in the Connecticut Medicaid program and are owned by "investment entities." The Act defines "investment entity" to mean any entity that collects capital investments and purchases a direct or indirect ownership share of a nursing home, or a real estate investment trust (REIT) as defined in 26 U.S.C. 856.

Investment Entity Ownership Disclosure Requirements

Section 1 requires that by February 15, 2027 and annually thereafter, each nursing home that participates in the Connecticut Medicaid program must provide DSS with the following information:

- Identification of all investment entities with 5% or more beneficial ownership interest in the nursing home;
- For each such investment entity, disclosure of the officers, directors, trustees, or managing and general partners and the number of shares owned or percentage interest held by each partner;
- If the investment entity is a corporation incorporated out-of-state, production of a certificate of good standing from the Secretary of State of the state of incorporation;
- The investment entity's audited financial statements, if applicable, including but not limited to (i) a balance sheet for the most recent fiscal year, (ii) an income statement for the most recent fiscal year, (iii) a cash flow statement for the most recent fiscal year, (iv) projected acquisition-related costs expected within one (1) year after acquiring the nursing home including financing expenses, legal expenses, land costs, marketing costs, and other similar anticipated costs or obligations;
- A description of all mortgage loans or other financing used to acquire or construct the nursing home, any refinancing of the existing acquisition or construction debt, and any subsequent financing arrangements involving additional debt. The terms and costs of such financing arrangements are also required to be disclosed;



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*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

- A copy of the nursing home purchase agreement and any agreements relating to the transfer of ownership interests in the facility, including real estate, asset purchase, stock purchase, and similar transaction documents; and
- Documentation relating to any escrow or contingency accounts.

DSS may impose civil penalties of up to $1,000 per day if a nursing home that participates in the Connecticut Medicaid program fails to provide required ownership and financial disclosure information within thirty (30) days after it is due, provided DSS gives written notice of the nondisclosure within fourteen (14) days of the filing deadline. Nursing homes may contest the penalty through the fair hearing process outlined in C.G.S. § 17b-60.

Financial Security Requirements

DSS must evaluate whether surety bonds, escrow accounts, insurance products, or other financial security instruments are available to a nursing home to guarantee ninety (90) days of the nursing home's operating costs payable to the State in the event of receivership, emergency closure, or financial distress. DSS must notify nursing homes of any qualifying security instruments by January 1, 2028.

Beginning July 1, 2028, nursing homes that participate in the Connecticut Medicaid program, with an investment entity holding a 5% or greater beneficial ownership interest must, as part of their DPH license renewal process, demonstrate that they have obtained and will maintain a surety bond or similar financial security in an amount equal to ninety (90) days of operating costs for the duration of the initial license term and any renewal term. In addition, a copy of the surety bond or similar financial security must be provided as part of the DPH license application. ***These requirements do not apply if DSS determines that no such instruments are available or financially feasible.***

Limitations on Nursing Home Control, Attestation and Waiver

Beginning February 1, 2028, each nursing home that participates in the Connecticut Medicaid program must retain full governance control and authority over all nursing home assets and operations, including all clinical, operational, managerial, financial, and human resources matters. Nursing homes that participate in the Connecticut Medicaid program must also annually attest to DPH that no investment entity exercises control over resident health, safety, or care. Failure to provide the attestation may result in a civil penalty of up to $2,000 per violation imposed by DPH. The civil penalty can be appealed by submitting a written request for hearing to DPH within ten (10) business days of receiving the order imposing the civil penalty. Timely requests for hearings will be heard as contested cases in accordance with Connecticut General Statutes chapter 54.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

Review of Disclosures

Section 2 requires that effective June 4, 2026, DSS, in consultation with DPH, must review and evaluate (i) the ownership and financial disclosures submitted by nursing homes, (ii) the quality of care at facilities with investment entity ownership compared to those facilities with other ownership structures, and (iii) the potential impact of restricting the sale, transfer, or other conveyance of nursing home real property within five (5) years of acquisition without DPH approval. DSS must report the results of its review to the General Assembly's Joint Committees on Human Services, Public Health, Appropriations and Aging by February 15, 2028.

4. PUBLIC ACT 26-76. AN ACT CONCERNING THE FAILURE TO FILE FOR CERTAIN GRAND LIST EXEMPTIONS, A MUNICIPAL OPTION TO ABATE DELINQUENT PROPERTY TAXES ON CERTAIN PARCELS OF LAND, ALLOCATIONS OF CERTAIN STATE FUNDS AND ITEMS IMPLEMENTING THE STATE BUDGET FOR THE BIENNIUM ENDING JUNE 30, 2027.
*Effective May 27, 2026, unless otherwise noted*

**§ 42 — Nursing Home Wage-Enhancement Rate Increases Revised**

See the consolidated discussion under Public Act 26-68 §§ 445–447, which describes the nursing home wage-enhancement rate increases as finally amended by Public Act 26-76 § 42.

**§ 43 — Nursing Home Bed Need and Replacement Facility Standards**

This Section amends C.G.S. § 17b-355, as amended by Public Act 26-74, which governs DSS review of requests involving nursing home beds, including bed relocations and replacement facilities. This Section adds that for projects involving the relocation of nursing home beds to establish room configurations of no more than two beds per room, DSS may establish bed need using an occupancy percentage below the otherwise applicable 96% threshold. This gives DSS flexibility to approve bed-relocation projects tied to compliance with the two-bed room policy even where area occupancy does not meet the usual bed-need standard. This Section otherwise retains the broader replacement-facility review framework, including DSS review of public need, quality, accessibility, cost-effectiveness, Medicaid-certified bed limits, closure of at least one existing facility, and consideration of nontraditional small-house style nursing facility models.

**§ 44 — Nursing Homes for Individuals Transitioning from Correctional or DMHAS Settings**

This Section amends C.G.S. § 17b-372a, which authorizes DSS and DMHAS, along with the Department of Corrections, to establish or contract for a chronic or convalescent nursing home to care for individuals who require nursing home level of care and are transitioning from a correctional facility or receive DMHAS services. The key change is that a nursing home developed under this special authority is not required to comply with the two-bed room requirement in C.G.S.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

§ 19a-521b(b), if that requirement conflicts with the statute. Existing law already exempted such facilities from the DSS bed-need approval provisions in C.G.S. §§ 17b-352 to 17b-354 where those provisions conflict.

**§§ 77–78 — Revisions to Public Act 26-68 Penalties for Unlicensed Operation of Health Care Institutions**
*Effective October 1, 2026*

See the consolidated discussion under Public Act 26-68 §§ 183–185, which describes the DPH unlicensed-operation and nursing facility management services certification penalties as finally amended by Public Act 26-76 §§ 77–78.

5. PUBLIC ACT 26-44. AN ACT REQUIRING FEAR OF RETALIATION TRAINING FOR PERSONS PROVIDING ASSISTED LIVING SERVICES IN MANAGED RESIDENTIAL COMMUNITIES.
*Effective October 1, 2026*

This Act imposes a new training requirement for licensed ALSAs that provide services to an MRC. Such ALSAs must ensure that all employees receive annual in-service training addressing residents' fears that employees or others may retaliate against them. At a minimum, the training must include: (i) a discussion of residents' rights to file complaints and voice grievances; (ii) examples of conduct that might constitute or be perceived as employee retaliation against a resident; and (iii) methods of preventing employee retaliation and alleviating residents' fear of such retaliation. The person conducting the training must be familiar with the needs of the resident population served by the ALSA at the particular MRC; however, the trainer need not be a qualified social worker or qualified social worker consultant.

6. PUBLIC ACT 26-113. AN ACT CONCERNING UTILITY CHARGES FOR RESIDENTIAL DWELLING UNITS.
*Effective October 1, 2026*

The Act amends C.G.S. § 47a-4 to prohibit rental agreements entered into or renewed on or after October 1, 2026, from requiring tenants to pay separately billed utilities unless a separate meter measures utilities delivered exclusively to the tenant's dwelling unit.

7. PUBLIC ACT 26-28. AN ACT CONCERNING THE USE OF TECHNOLOGY FOR VIRTUAL MONITORING IN RESIDENTIAL CARE HOMES.
*Effective October 1, 2026*

This Act establishes a new statutory framework granting RCH residents the right to use technology for virtual monitoring and makes conforming amendments to the existing immunity provisions for virtual monitoring in CCNHs.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

**§ 1 — RCH Residents' Right to Use Video Monitoring Technology**

This Section establishes new rights for RCH residents to use technology for virtual monitoring, largely modeled after the current nursing home virtual monitoring statute at C.G.S. § 19a-550b.

Under the new law, RCH residents have the right to use technology of their choice to facilitate virtual monitoring in their room or living quarters, subject to specific notice, consent, and privacy requirements, as follows:

- Resident Right. Residents may use technology of their choice for virtual monitoring by a third party. Permitted technology includes devices that are capable of remote audio or video communications, including devices with recording capabilities.
- Ownership and Cost. The technology must be owned and operated by the resident in the resident's room or living quarters. Residents will be responsible for the expenses related to the purchase, activation, installation, maintenance, repair, operation, deactivation and removal of the technology.
- Signage Requirement. A clear and conspicuous notice must be placed on the resident's door to indicate that technology involving virtual monitoring may be in use.
- Notice and Consent Requirements for Shared Rooms. In shared living situations, the resident or resident representative must provide advance notice to any roommate or the roommate's representative specifying the type of technology to be used, its proposed location and intended use, and its audio, video and remote activation capabilities along with its intended hours of operation. Written consent from all roommates or their representatives must be obtained before using virtual monitoring technology in a shared living space. If any roommate withdraws consent, the resident must cease using the technology until consent is obtained and must provide the RCH with written notice within seven (7) days of such withdrawal.
- Advance Notice to RCH. A signed, written notice and a copy of any written consent of roommates must be filed with the RCH no less than seven (7) days before use or installation of such technology, and such notice must (i) identify the type of, intended use, hours of operation and location of such technology, (ii) specify any audio, video or remote activation or control capabilities of such technology, (iii) acknowledge the resident's responsibilities for the purchase, activation, installation, maintenance, repair, operation, deactivation and removal of the technology and (iv) include a waiver of all civil, criminal and administrative liability for the RCH.
- Privacy Requirement. Any technology, recordings and images obtained from such use by the resident or any person communicating with or monitoring such resident, must not violate any other person's right to privacy under state or federal law.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

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

Additionally, RCHs may choose to establish policies and procedures for virtual monitoring technology that address (i) placement of the device in a visible, stationary location, (ii) restrictions on use of the technology to record outside the resident's room or in shared common spaces, (iii) compliance with federal, state and local life safety and fire protection requirements, (iv) limitations when virtual monitoring would interfere with care or privacy, unless consent is obtained, (v) limitations in the event the RCH's internet service is disrupted, and (vi) actions the RCH may take for noncompliance with laws, policies or processes and the process for the resident to appeal such actions.

This Section allows the Connecticut Long-Term Care Ombudsman (LTCO) to develop, in consultation with RCH representatives and DPH, standard forms on its website for use by an RCH resident seeking to do any of the following: (i) notify the RCH that the resident plans to install and use technology for virtual monitoring; (ii) obtain roommate consent for the possible capture of such roommate's audio or video through the virtual monitoring technology; and (iii) notify the RCH that the roommate has withdrawn consent to the use of the virtual monitoring technology.

RCHs are immune from civil, criminal and administrative liability for (i) state law privacy rights violations caused by a resident's use of technology in accordance with the Act, (ii) damage to the technology not caused intentionally or negligently by the RCH and (iii) inadvertent use or intentional disclosure, interception or use by an unauthorized third party of the audio or video produced by the resident's technology, provided that the RCH did not intentionally cause the disclosure, interception, or unauthorized use. Lastly, this Section also allows DPH to adopt regulations to implement the requirements of this Section.

See Wiggin and Dana's memo summarizing Connecticut laws regarding the use of resident-owned virtual monitoring and recording technology in Nursing Homes, Residential Care Homes, and Managed Residential Communities, attached at **Appendix A**.

### § 2 — Amendments to Nursing Home Immunity

Section 2 amends C.G.S. § 19a-550b(d) to modify the scope of CCNH immunity related to resident use of virtual monitoring technology by (i) eliminating immunity for violations of federal privacy laws, thereby limiting immunity to claims arising under state privacy laws caused by the resident's use of the technology in compliance with the statutory requirements, (ii) revising the immunity standard for damage to resident-owned technology by providing immunity unless the damage is caused "intentionally or negligently" by the CCNH, rather than only through negligence, and (iii)



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

extending immunity for the unauthorized disclosure, interception, or use of audio or video recordings produced by the resident's technology, provided that the CCNH did not intentionally cause the disclosure, interception, or unauthorized use.

8. PUBLIC ACT 26-71. AN ACT CONCERNING A PILOT PROGRAM TO TREAT CERTAIN MEDICAID PATIENTS AT A SHORT-TERM HOSPITAL SPECIAL HOSPICE.
*Effective July 1, 2026*

   This Act requires DSS to develop a pilot program for Medicaid patients with advanced illness who qualify for hospice and are clinically complex, high-acuity individuals who cannot be safely managed at home or in a skilled nursing facility. The pilot will identify and use a short-term hospital special hospice licensed under C.G.S. § 19a-491, but the hospice may not provide services outside the scope of its license without obtaining any required additional licensure. By January 15, 2027, DSS must report to the General Assembly's Joint Committee on Appropriations, Human Services and Public Health on the pilot's development, potential savings and any recommended funding or statutory changes. DSS must implement the pilot by December 30, 2027, within available appropriations.

9. SPECIAL ACT 26-27. AN ACT CONCERNING PALLIATIVE AND HOSPICE CARE IN LITCHFIELD COUNTY.
*Effective June 2, 2026*

   This Act directs DSS, in consultation with DPH, to study the need for palliative and hospice care services in Litchfield County. In conducting the study, DSS must take into consideration any findings concerning the need for such services by the Palliative Care Advisory Council. By January 1, 2027, DSS must file a report with the General Assembly's Joint Committees on Human Services and Public Health. If the study concludes that there is a need for such services, DSS may, within available appropriations, design and implement a pilot program to provide palliative and hospice care in Litchfield County and must maximize federal funding available for the pilot program by seeking a Medicaid waiver or amending the Medicaid state plan to obtain the funding.

10. PUBLIC ACT 26-50. AN ACT REQUIRING TRAINING FOR HOMEMAKER-COMPANION AGENCY EMPLOYEES.
*Effective May 20, 2026, except as otherwise noted*

    This Act establishes employee training requirements for homemaker-companion agencies ("HCAs") and modifies existing advertising rules applicable to HCAs.

    **§ 1 — New Training Requirements**

    On and after January 1, 2027, each HCA must provide each employee at least eight (8) paid hours of training, consisting of (i) initial training to new employees and (ii) annual continuing education.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

These training requirements do not apply to registered nurse's aides, home health aides, personal care attendants or any employee who does not provide homemaker or companion services.

Initial Training

Each new hire must receive initial training that includes programming relating to (i) maintenance of a clean and safe environment, including, but not limited to, best practices relating to dressing, bathing and toileting assistance, (ii) identification and reporting of abuse and neglect and (iii) identification and reporting of changes in a client's condition and service needs. If the employee will serve clients with Alzheimer's disease or dementia, the initial training must also address providing nonmedical services to such persons. Initial training must be completed within ninety (90) days of the new employee's start of employment, unless the employee presents proof of equivalent training received by a different HCA within three (3) years preceding the date of hire. The employee must provide documentation of the prior training by submitting the attestation form described below. The HCA must retain a copy of the form in the employee's personnel file as evidence of compliance.

Continuing Education

On and after January 1, 2027, HCAs must also provide annual continuing education to each existing employee concerning (i) communication, (ii) maintenance of a clean and safe environment, including, but not limited to, best practices relating to dressing, bathing and toileting assistance, (iii) identification and reporting of abuse and neglect, (iv) identification and reporting of changes in a client's condition and service needs, (v) differentiation between medical and nonmedical care, (vi) providing nonmedical services to persons with Alzheimer's disease or dementia and (vii) any other topic deemed appropriate by DCP, in consultation with DPH, DSS, DDS and DMHAS.

Development of Training Programs

By October 1, 2026, DCP must develop, in consultation with DPH, DSS, DDS and DMHAS, a list of approved training programs on the topics enumerated above and publish a list of approved trainings on DCP's website. Employees must complete each program included on the approved list at least once every two (2) calendar years. In addition, HCAs must maintain a list of their training programs, including summaries of the program content.

Attestation Forms

Upon completion of the required employee training, the HCA and employee must complete an employee training attestation form, developed by DCP, that confirms completion of the training and includes (i) the names of both the agency and the employee, (ii) the training programs completed by the employee, (iii) the dates of completion and (iv) the signatures of both an agency



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

representative and the employee. HCAs must maintain copies of the employee training attestation form in paper or electronic format.

In addition, by January 1, 2027, and annually thereafter, each HCA must submit an attestation form to DCP confirming that the HCA agrees to comply with the applicable training requirements. Each HCA must also maintain a list of training programs provided, including content summaries of each program.

Compliance by HCA Registries

HCA registries must ensure that any individual supplied, referred or placed with a consumer, has undergone the required training before such placement.

**§ 2 — Modification to Existing Advertising Rules**
*Effective January 1, 2027*

This Section amends the statute governing HCA advertising to permit HCAs to include statements that the HCA complies with all applicable State training requirements. HCAs may also reference specific training program topics described in this Act when advertising their services.

11. PUBLIC ACT 26-72. AN ACT CONCERNING VARIOUS REVISIONS TO HUMAN SERVICES STATUTES.
*Effective July 1, 2026, except as otherwise noted*

**§ 1 — MRC Resident Bill of Rights Posting Requirements**

This Section amends the MRC resident bill of rights posting requirement to add that the posting must include contact information for DSS to report suspected abuse, neglect, exploitation or abandonment of an elderly person, or to report that an elderly person may be in need of protective services. See revised Model Managed Residential Community Resident Bill of Rights, attached at **Appendix B**.

**§ 3 — DDS Registry Access for Charitable Organizations**
*Effective June 2, 2026*

This Section amends the rules governing access to DDS's abuse and neglect registry. Existing access remains limited to specified entities and purposes, including authorized agencies for protective service determinations; certain employers and state agencies for employment-related checks; and the Probate Court Administrator for proposed guardian appointments. The new change adds charitable organizations that recruit volunteers to support programs for persons with intellectual disability or autism spectrum disorder. Those organizations may access registry information only after applying to and receiving approval from the DDS Commissioner, and only for purposes of conducting background checks on those volunteers.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

**§ 5 — Long-Term Care Planning Committee Revisions**

This Section updates the statute governing the Long-Term Care Planning Committee, which is responsible for coordinating long-term care policy and developing a statewide long-term care plan. The plan must continue to address long-term care across home and community-based services, supportive housing arrangements and nursing facilities, with the goal of enabling individuals to receive care in the least restrictive appropriate setting. The Section reorganizes and expands the Committee's study topics to include long-term care financing models, workforce retention, wages and standards, projected federal support and funding gaps, Medicaid case-mix reimbursement, community-based service options, access to long-term care and geriatric psychiatric services, the Olmstead community-integration mandate, and comparative Medicaid expenditure data for nursing homes and Home and Community Based Services (HCBS) waiver participants who require a nursing home level of care. It also updates the Committee's membership and chair structure, designates the OPM Secretary or designee as a chairperson, and adds House and Senate chairpersons elected from the legislative members. The annual report must address the Committee's study topics and include listings of long-term care supports and services in the community and in institutions, while the triennial long-term care plan remains the guide for state agency action. The Section also retains language directing state agencies, when feasible, to support family and informal caregivers and consumer-directed care. The Section also adds a new requirement that, by January 1, 2028, the Committee report on how Public Law 119-21, the 2025 federal budget reconciliation law containing significant Medicaid financing and eligibility changes and other recent federal regulatory changes may affect the financing of long-term care options in Connecticut.

**§ 6 — Long-Term Care Advisory Council Membership Updates**

This Section updates the membership and governance of the Long-Term Care Advisory Council, which advises the Long-Term Care Planning Committee on long-term care planning and study issues. The changes include updating the LeadingAge seat to reflect the current name, LeadingAge Connecticut & Rhode Island, Inc.; revising the legal services seat to allow a representative from CT Legal Services, Greater Hartford Legal Aid or New Haven Legal Assistance Association; adding the Secretary of OPM, or designee; and adding the House and Senate chairpersons and ranking members of the Human Services Committee, or their designees. The Section also provides that the House and Senate Human Services Committee chairpersons jointly appoint the Council chairpersons. The Council must continue seeking recommendations from persons with disabilities and persons receiving long-term care services who reflect the state's socioeconomic diversity.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

**§ 7 — DPH Health Data Advisory Committee Membership**
*Effective June 2, 2026*

This Section updates the name of the organization responsible for appointing one member of the DPH health data advisory committee to reflect the current name, LeadingAge Connecticut & Rhode Island, Inc. No substantive changes were made to the committee's role.

**§ 8 — Nursing Home Administrator Continuing Education**
*Effective June 2, 2026*

This Section updates the list of organizations whose courses qualify for nursing home administrator continuing education credit to reflect the current name, LeadingAge Connecticut & Rhode Island, Inc. Required continuing education subjects continue to include Alzheimer's disease and dementia symptoms and care, and infection prevention and control. No substantive change to the continuing education requirement is made.

**§ 10 — Federal Nursing Home Regulations on Antipsychotics and Informed Consent**

This Section incorporates into Connecticut law two federal nursing home resident-protection standards as they existed on January 1, 2026: (i) 42 C.F.R. § 483.45(e), governing antipsychotic medication use, and (ii) 42 C.F.R. § 483.10(c), governing resident participation in treatment decisions. Connecticut law already includes nursing home resident-rights protections, including rights to be informed of the resident's medical condition, participate in treatment planning, refuse experimental research, and be free from restraints not needed to treat the resident's medical condition. The federal rules are more specific in certain respects. The antipsychotic-drug rule generally requires that residents who have not previously used antipsychotics not receive them unless necessary to treat a specific documented condition, that residents using psychotropic drugs receive gradual dose reductions and behavioral interventions unless clinically contraindicated, and that PRN antipsychotic orders be limited and renewed only after appropriate evaluation. The informed-participation rule more specifically addresses the resident's right to be informed of and participate in care and treatment planning, be informed in advance of proposed care and treatment options and their risks and benefits, and request, refuse or discontinue treatment. By incorporating these federal standards by reference, the Section gives them the same force and effect under state law as if fully written into the Connecticut General Statutes.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

12. PUBLIC ACT 26-74. AN ACT CONCERNING PUBLIC HEARINGS FOR CERTAIN RATE INCREASES AT ASSISTED LIVING FACILITIES, MUNICIPAL AGENTS FOR AGING, EMERGENCY POWER GENERATOR REQUIREMENTS FOR CERTAIN MULTIFAMILY HOUSING PROJECTS, PERSONAL PROTECTIVE EQUIPMENT FOR HOME HEALTH AIDE EMPLOYEES, THE NURSING HOME BED MORATORIUM AND NURSING HOME RESIDENT DATA.
*Effective October 1, 2026, except as otherwise noted*

**§ 1 — Assisted Living Informational Hearing on Fee Increases**

This Section amends the ALSA licensure statute, C.G.S. § 19a-564, by adding a new requirement for certain fee increases. Under the amendment, if an ALSA increases a fee by more than 10% of the previous fee, the ALSA must hold an informational hearing at least thirty (30) days before the fee increase takes effect. The hearing must provide residents, their representatives, and family members an opportunity to comment on the proposed increase. This requirement is in addition to the existing obligation to provide residents or their representatives with at least sixty (60) days' advance notice before any fee increase takes effect.

**§ 2 — Municipal Agents for Aging**
*Effective May 27, 2026*

This Section renames "municipal agent for elderly persons" as "municipal agent for aging" and updates related terminology throughout the municipal agent statute to replace "elderly persons" with "older adults." The amendment also adds a new conflict of interest provision requiring each municipality to appoint a municipal agent who is free from actual or potential conflicts of interest that could compromise the agent's ability to provide unbiased information, assistance, and referral services. The statute broadly defines "conflict of interest" to include "the receipt of any financial or personal benefit by a municipal agent, such agent's spouse, parent, sibling, child or child's spouse or a business associated with such agent."

Effective July 1, 2026, municipal agents must submit a written certification upon appointment or reappointment, to the Department of Aging and Disability Services, attesting that they are unaware of any actual or potential conflicts of interest. If an actual or potential conflict arises during the agent's term, the agent must immediately report it, and any interested party may also report it, to the appointing authority. The appointing authority must then determine whether another municipal agent or employee can act in place of the affected agent to eliminate the conflict. The appointing authority may consult with the Department of Aging and Disability Services in making its determination.

This Section also authorizes two (2) or more municipalities to jointly appoint one (1) or more municipal agents pursuant to a memorandum of agreement or understanding, including for the purpose of sharing expenses associated with the municipal agent(s).



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

**§ 3 — Emergency Power Generators for Certain Multifamily Age-Restricted Housing**

This Section amends public safety statutes governing emergency backup power requirements for privately owned multifamily housing projects. Current law defines "privately owned multifamily housing projects" as those with buildings that are (i) at least fifteen (15) stories in height with age restricted dwellings and (ii) subject to a mortgage insured under the National Housing Act. Existing law requires these private multifamily housing projects to install and maintain one or more emergency generators capable of providing four (4) to twelve (12) hours of backup power for essential services within residential units, including heating, water, lighting, and critical medical equipment, as well as passenger elevators. The amendment expands the population limit for municipalities where housing projects covered by the law will be subject to this requirement. The law will now apply to privately owned multifamily housing projects located in municipalities with a population of at least 130,000 but less than 140,000, as determined by the 2020 federal decennial census, increasing the current upper population threshold from 135,000 to 140,000.

**§ 4 — Personal Protective Equipment for Home Health Aide Employees**

This Section creates new law requiring each home health aide agency to provide home health aide employees, at no cost, with any personal protective equipment (PPE) necessary to safely provide home health aide services to each client. "Personal protective equipment" is defined as including disposable gloves, hand sanitizer, aprons, gowns, foot covers, face shields, N95 masks or higher rated masks certified by the National Institute for Occupational Safety and Health and surgical masks. This requirement to provide PPE applies to both HHA employees and individuals contracted by the HHA to provide home health aide services.

**§ 5 — Nursing Home Bed Moratorium Exception**
*Effective May 27, 2026*

This Section creates a new exception to the nursing home bed moratorium. Under the amendment, DSS may now approve requests for new Medicaid certified beds in existing or newly established nursing homes. In evaluating such requests, DSS must give preference to a nontraditional, small-house-style nursing home that incorporates the goals for nursing facilities referenced in DSS' strategic plan for long-term care, to address priority needs identified through local census trends.

**§ 6 — Certificate of Need Criteria Amendments**
*Effective May 27, 2026*

This Section makes several amendments to DSS' criteria for evaluating certificate of need ("CON") requests submitted by CCNHs, RCHs and intermediate care facilities for individuals with intellectual disabilities. First, when evaluating the quality, accessibility and cost-effectiveness of long-term care delivery in the region, DSS may now consider a nursing home's star rating on the Centers for Medicare & Medicaid Services' Five-Star Quality Rating System. Second, the



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

amendment extends DSS' existing authority to make a public need determination for the relocation of beds to a replacement facility, to also apply to CON requests for adding new beds at existing or newly established facilities. Third, the amendment revises the methodology for demonstrating bed need based on recent occupancy percentage of area nursing homes by making the following changes: (i) lowering the recent occupancy percentage threshold from 97.5% to 96%, and requiring that the 96% occupancy be maintained for at least two (2) consecutive quarters to establish a need, (ii) reducing the projected bed need standard from 97.5% occupancy to occupancy exceeding 96%, (iii) eliminating the five (5) year limitation on projected bed need calculations; and (iv) replacing the prior reliance on OPM's population projections and DPH's nursing facility utilization statistics with DSS' strategic statewide long-term rebalancing plan, as the basis for determining occupancy metrics and future bed need.

**§ 7 — Nursing Home DSS Minimum Data Set Audits**
*Effective July 1, 2026*

This Section expands DSS' audit authority by requiring DSS to conduct audits of minimum data set ("MDS") information, the resident assessment tool required by CMS, which DSS uses to calculate Medicaid acuity-based per diem rates for CCNHs. While these audits will generally be conducted pursuant to existing Medicaid audit procedures for long-term care providers outlined in C.G.S. § 17b-99a, MDS audits will be subject to more stringent procedural requirements. Specifically, CCNHs must respond to DSS document requests within ten (10) days, and DSS will not accept additional documentation after the exit conference absent mutual agreement between DSS and the CCNH to permit such submission.

This Section further amends C.G.S. § 17b-99a by expanding the scope of the payment suspension provisions applicable to Medicaid audits of long-term care facilities. Under the amendment, payment suspensions may be imposed for the submission of **any** false or misleading information or data, rather than being limited to false or misleading "fiscal" information or data.

## III. ACTS AFFECTING VARIOUS HEALTH CARE PROVIDERS

13. PUBLIC ACT 26-22. AN ACT CONCERNING HOSPITAL SALE-LEASEBACK TRANSACTIONS AND ATTESTATIONS CONCERNING LACK OF A CONTROLLING INTEREST OF A HOSPITAL OR OF INTERFERENCE WITH THE PROFESSIONAL JUDGMENT AND CLINICAL DECISIONS OF CERTAIN HEALTH CARE PROVIDERS OF A HOSPITAL BY A PRIVATE EQUITY ENTITY.
*Effective May 27, 2026*

**§ 1 — Prohibition on Hospital Sale-Leaseback Transactions**

This Section prohibits a hospital from entering into a sale-leaseback transaction on or after July 1, 2027. The Act defines "private equity entity" as any entity that collects capital investments and



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

purchases a direct or indirect ownership share of a hospital. The Act defines "sale-leaseback transaction" as a transaction in which a hospital sells and leases back hospital-owned real property constituting the main campus of a hospital.

**§ 2 — Annual Private Equity Attestation Requirements**

By February 15, 2027, and annually thereafter, each hospital must submit the following to DPH:

- An attestation that no private equity entity has (i) a controlling interest in the hospital or (ii) ultimate governance control and authority over any asset or activity of the hospital's main campus, including clinical, operational, managerial, financial or human resources matters; and
- An attestation that no private equity entity directs the hospital's adoption of policies or procedures that would interfere with clinicians' professional judgment or clinical decision-making, including decisions regarding (i) the amount of time spent with patients or the number of patients seen within a given timeframe; (ii) emergency department triage and patient evaluation timeframes; (iii) patient discharge timing; (iv) clinical care decisions, including observation status, palliative care, and discharge placement; (v) diagnoses, medical record entries, diagnostic terminology, and coding; and (vi) the selection of appropriate diagnostic tests.

Failure to provide the attestations may result in a civil penalty imposed by DPH of up to $2,000 per violation. The civil penalty can be appealed by submitting a written request for hearing to DPH within ten (10) business days of receiving the order imposing the civil penalty. Timely requests for hearings will be heard as contested cases in accordance with Chapter 54 of the Connecticut General Statutes.

The Act expressly states that its requirements do not prohibit hospitals or their affiliates from participating in joint ventures or contracting with physicians or physician groups to provide services at the hospital. The Act also clarifies that its provisions are not intended to interfere with a hospital's coordination with its parent health system.

14. PUBLIC ACT 26-12. AN ACT CONCERNING WORKFORCE DEVELOPMENT AND WORKING CONDITIONS IN THE STATE.
*Effective October 1, 2026, except as otherwise noted*

**§ 1 — Workers' Compensation for Health Care Workers Assaulted on the Job**

This Section expands workers' compensation protections for certain health care workers who are injured in a physical or negligent assault while performing their job duties. Covered workers include: (1) health care providers who work or volunteer for a covered health care facility or



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

institution and provide direct patient care or have direct contact with patients or their families in connection with patient records, escorting or directions on the premises; and (2) other employees of covered health care facilities or institutions. Covered facilities include, among others, hospitals, nursing homes, rest homes, home health care agencies, home health aide agencies, emergency medical services organizations, assisted living services agencies, outpatient clinics and community health centers, but generally exclude state-operated facilities other than UConn Health Center.

During the period the injured employee is incapacitated because of the assault-related injury, the employee is entitled to weekly compensation equal to 100% of the employee's average weekly earnings, without reduction based on the statutory maximum weekly compensation rate. The weekly compensation must also include payment for expenses reasonably incurred for medical or other services necessary as a result of the assault and for lost wages due to an absence for a court appearance in connection with the assault. The Section also prohibits the employer from charging time lost because of the injury or related court appearance against the employee's sick, vacation or personal leave.

In addition, any covered health care provider or other employee who is absent from employment because of an injury sustained during the assault or for a court appearance in connection with the assault must continue to receive the employee's full salary while absent, except that the amount of any workers' compensation award may be deducted from the salary payments during that absence. In other words, the employee should continue receiving full salary while out of work for the assault-related injury or for a related court appearance, but the employer does not have to pay both full salary and duplicative workers' compensation benefits for the same lost time. Any workers' compensation award for that period may be credited against the salary continuation payments.

**§ 2 — Wage and Benefits Transparency**

This Section amends the wage transparency law to add a new definition of "benefits" (health insurance, retirement benefits, fringe benefits, paid leave and any other non-wage compensation) and revises the definition of "wage range" to mean the range an employer "sets in good faith" rather than "anticipates relying on when setting wages." Employers are required to disclose a general description of benefits along with the wage range to applicants, employees and in job advertisements. Employers must now provide this information prior to any discussion of compensation rather than at the time an offer is made. These provisions apply to in-state employees as well as out-of-state employees who report directly to a supervisor, office or other worksite located within the state.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

**§ 3 — Working Group on Patient Violence Reporting via Health Information Exchange**
*Effective May 11, 2026*

This Section establishes a working group to study the feasibility of implementing a system through which health care providers with electronic health records connected to the CONNIE could report incidents of patient violence directed at providers, and receive alerts when accepting or scheduling a patient with a documented history of such violence. The working group must report to the General Assembly's Joint Committee on Public Health by January 1, 2027.

**§ 4 — Prohibition on Employment Promissory Notes**

This Section amends existing law prohibiting employers from requiring that an employee sign, as a condition of employment, a promissory note that requires the employee to pay the employer any sum of money if the employee leaves employment within a specified time. This amendment eliminates the prior 26-employee threshold, extending the prohibition on employment promissory notes to all employers regardless of size. Effective October 1, 2026, no employer may require, as a condition of employment, that an employee or prospective employee execute an instrument requiring payment if the employee leaves before a stated period. Such notes remain void as against public policy. Existing exceptions are preserved for repayment of sums advanced, employer-sold property, sabbatical leave terms and collective bargaining agreements.

**§ 9 — Displaced Worker Protection (Service Contract Transitions)**
*Effective July 1, 2027*

This Section creates a new displaced-worker retention law, effective July 1, 2027, for certain service-contract changes and property transfers. In general, it applies when specified service work is performed at a covered location and there is a termination or nonrenewal of a service contract, the start of a successor service contract, or the sale or transfer of property where employees worked during the ninety (90) days before the sale or transfer.

For purposes of this Section, the key definitions can be summarized as follows:

- **Awarding authority.** The person or entity that contracts for services at a covered location, or that sells or transfers control of property where employees worked during the ninety (90) days before the sale or transfer.
- **Contractor.** A person that enters into a service contract with the awarding authority, including any subcontractor at any tier, and employs two or more persons.
- **Employer.** A person that employs two or more employees, including a municipal or local government, but excluding the federal government, the state and the Connecticut Airport Authority.



*LeadingAge Connecticut & Rhode Island, Inc.*
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*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

- **Covered location.** A broad category of worksites, including multifamily residential buildings or complexes with 50 or more units; commercial centers, complexes or office buildings occupying more than 75,000 square feet; municipal office buildings or facilities; public and nonpublic schools; cultural centers or complexes, including museums, convention centers, arenas and performance halls; shopping malls and bank branches; industrial sites; pharmaceutical labs; airports; train stations; warehouses, distribution centers and similar storage or distribution facilities; and independent institutions of higher education. ***The final Act does not expressly include hospitals, nursing homes, or MRCs as covered locations, even though earlier bill language would have included hospitals, nursing home facilities and institutions operated or managed by ALSAs. Accordingly, Section 9 should not be read to apply to those providers merely because they operate health care or senior-living settings. However, where a MRC includes a separate apartment-style residential component with fifty or more units, the organization should consider whether that particular component could independently qualify as a "multifamily residential building or complex with fifty or more units." The licensed nursing home or assisted living/service component should not automatically be treated as covered on that basis absent further guidance.***
- **Employee.** A person who works at least sixteen (16) hours per week and has performed covered work at a covered location for at least sixty (60) days. The term excludes managerial, supervisory and confidential employees, including those defined that way under the federal Fair Labor Standards Act, and persons performing work on municipal-permit projects, such as building, mechanical, plumbing, structural or electrical projects.
- **Covered work.** Care or maintenance services at a covered location, including work performed by security guards, front-desk workers, janitors, housekeepers, maintenance employees, concierges, door attendants, building superintendents, grounds maintenance workers, stationary firemen, elevator operators and window cleaners.
- **Successor employer.** An employer that receives a successor service contract, purchases or acquires control of property where employees worked during the prior ninety (90) days, or is an awarding authority that brings in-house substantially the same services previously provided under a terminated or nonrenewed service contract.
- **Successor service contract.** A service contract for substantially the same services previously provided to the awarding authority under another service contract or by the awarding authority's own employees.
- **Terminated contractor.** A contractor whose service contract expires without renewal or is terminated. The term also includes the awarding authority when prior in-house work



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

becomes subject to a successor service contract or when the awarding authority sells or transfers property where employees worked during the prior ninety (90) days.

**Termination Notice.** At least fifteen (15) days before the termination or nonrenewal of a service contract, the start of a successor service contract for services previously performed by the awarding authority's own employees, or the sale or transfer of property where employees worked during the preceding ninety (90) days, the awarding authority must, where applicable, give advance notice to the terminated contractor, the terminated contractor's affected employees and any exclusive bargaining representative of those employees. The notice must be provided in writing to each affected employee and posted in a conspicuous place at the worksite. If known, it must include the name, telephone number and address of the successor employer(s).

**Provision of Employee Information**. Within three (3) days after receiving the awarding authority's notice, the terminated contractor must provide the successor employer with the name, date of hire and employment occupation classification of each employee employed at the affected site or sites as of the date the notice is received. On the actual transition date (the service contract termination date, the successor service contract start date, or the property sale or transfer date), the terminated contractor must provide the successor employer with updated employee information so the name, date of hire and employment occupation classification information is current as of that date. If the awarding authority has not identified the successor employer, the terminated contractor must provide the updated employee information to the awarding authority within three (3) days after receiving the required notice, and the awarding authority must provide the information to the successor employer as soon as the successor employer is selected.

**Employee Retention.** Generally, the successor employer must retain, for at least ninety (90) days from first performance of services under the successor contract or after the property sale or transfer, all employees who were continuously employed at the affected site or sites during the ninety (90) days immediately preceding the transition, including periods of layoff or leave with recall rights. If a successor service contract is terminated before that ninety (90)-day period ends, the next successor employer must begin a new ninety (90)-day retention period for employees who were continuously employed during the ninety (90) days before the most recently terminated contract. Importantly, the statute does not require a successor employer to retain an employee whose attendance and performance records while working under the terminated service contract would lead a reasonably prudent employer to terminate the employee. Also, for a property purchase or acquisition, the retention obligations apply only when the services to be performed at the affected site or sites are substantially the same as the services previously provided by the terminated contractor's employees. If the successor employer determines that fewer employees are needed to perform the successor service contract or services at the purchased or acquired property, it must retain employees by seniority within each job classification, based on total length of service at the affected site or sites. During the ninety (90)-day period, the successor employer must maintain a



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*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

preferential hiring list of employees eligible for retention but not initially retained and must hire additional employees from that list if additional covered positions become available.

**Offer of Employment.** The successor employer must hand-deliver a written offer of employment to each eligible employee in the employee's native language or another language in which the employee is fluent. The offer must be provided at least five (5) days before the service contract ends, or at least fifteen (15) days before the first performance of service under the successor contract or after the property sale or transfer, whichever is later. The offer must be substantially in the statutory form, include the offered pay rate, hours, weekly hours and benefits, and give the employee at least ten (10) days from the date of the offer to accept.

**Discharge Prohibition.** The successor employer may not discharge a retained employee during the 90-day period without just cause, which is determined solely by the performance or conduct of the particular employee. After the ninety (90)-day period, the successor employer must provide each retained employee a performance evaluation and, if the employee's performance was satisfactory, offer continued employment under the terms and conditions established by the successor employer or as required by law.

**Penalties.** An employee or group of employees displaced or terminated in violation of this Section, or their collective bargaining representative, may bring an action in Superior Court against the awarding authority, terminated contractor or successor employer, jointly or severally, or may file a complaint with the Labor Commissioner. A claimant may not file a Labor Commissioner complaint based on the same facts and circumstances as a civil action unless the court action has been withdrawn or dismissed without prejudice, and exhaustion of administrative remedies is not required before filing suit. If a court or the commissioner finds a violation, relief may include back pay, including the value of benefits, interest and the statutory pay-rate calculation; reinstatement to the employee's former position at not less than the most recent compensation rate, including benefits; compensatory damages; and reasonable attorney's fees and costs. A successor employer that fails to retain or unlawfully discharges an employee must pay a civil penalty of $500 to $1,000 per employee for each day the violation continues. An awarding authority or terminated contractor that violates the notice or employee-information requirements must pay a civil penalty of $50 to $200 per employee for each day the violation continues. An aggrieved party may appeal the Labor Commissioner's decision to Superior Court under the UAPA, and the Labor Commissioner may ask the Attorney General to bring a Superior Court action for employee damages and appropriate injunctive or equitable relief.



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*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

**§ 16 — Virtual Monitoring Evidence in Direct Care Disciplinary Actions**
*Effective July 1, 2026*

This Section governs when DSS may provide access to evidence from virtual monitoring that is used in a proposed disciplinary action involving certain direct care employees. For purposes of this Section:

- **Virtual monitoring** means remote monitoring of an individual receiving direct care services by a third party, using technology owned and operated by the individual in the individual's living quarters.
- **Direct care services** means services provided in an agency, facility, home or community-based setting to an individual enrolled in a program administered by DDS or DSS.
- **Employee organization** means an organization involved, in whole or in part, in collective bargaining, grievance handling, employment terms or conditions, or other mutual aid or protection.

DDS and DSS may, to the extent permitted by law, provide access to evidence derived from virtual monitoring, and related evidence, that is used in a proposed disciplinary action against an employee of a nonprofit organization that contracts with a state agency to deliver direct care services; an employee of a contractor providing those services; or an employee organization representing that employee. Access is conditioned on the employee and employee organization signing a department-provided or department-approved confidentiality agreement, treating recordings and images from the virtual monitoring technology as confidential, and not copying, reproducing or further disseminating those recordings or images except as necessary to represent and defend the employee in the disciplinary matter or as otherwise required by law.

DDS and DSS must ensure that any access granted under this Section does not violate HIPAA or any other applicable federal or state law. By July 1, 2027, the DDS and DSS Commissioners must implement the policies and procedures necessary to carry out the Section while they proceed with formal regulations. The policies and procedures may remain in effect until final regulations are adopted, provided the departments publish notice of their intent to adopt regulations on their websites and the eRegulations System within twenty (20) days after implementation.

**§ 17 — PCA Fiscal Intermediary Reporting**
*Effective July 1, 2026*

This Section requires DSS to submit quarterly reports to the General Assembly's Joint Committees on Human Services and Labor regarding the fiscal intermediary's administration of Medicaid self-directed home care programs. The report must include the following information: (i) payroll processing error rates for PCAs and the length of time until payment after correction of the



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

processing error, (ii) length of time required for the fiscal intermediary to onboard new employees to enable them to use the payroll system, (iii) average response time for the fiscal intermediary to answer phone calls, including the volume of calls related to incidents described in these reports, and emails from PCAs or consumers about general customer service requests, (iv) number and average resolution time of electronic visit verification tickets received by the fiscal intermediary, and (v) average length of time the fiscal intermediary's mobile application was inoperable or offline. The report will exclude public records that are exempt from disclosure under the Freedom of Information Act, including personnel files and other information that would constitute an invasion of personal privacy.

**§ 34 — CNA Training Program Expansion Grants**
*Effective May 11, 2026*

This Section requires DPH to establish and administer a grant program, within available appropriations, to expand certified nursing assistant training programs in the greater Hartford area and rural communities. The program will utilize federal funds provided under the Rural Health Transformation Program. DPH must submit a biennial implementation report to the General Assembly's Joint Committee on Public Health beginning December 31, 2028.

**§ 38 — Pay Code Guides for Large Employers**

This Section amends the pay stub law to require employers with 100 or more employees to create a guide for pay codes covering overtime and the employer's most used pay differentials such as shift differentials, on-call pay, hazard pay, call-back pay, holiday or weekend pay or geographic pay differentials. The guide must include at least ten pay codes and be posted on the employer's website in English, Spanish and the other common languages spoken by employees, with contact information for the office handling pay disputes. The employer must update the guide each time the employer adds a new pay code used for overtime or any pay differentials. The guide must be provided to employees upon hire and its web address included on each pay record. If an employer uses a third-party payroll service company that provides a guide for pay codes in compliance with this Section, then the employer is deemed in compliance with the Section's requirements.

15. PUBLIC ACT 26-100. AN ACT CONCERNING CONSUMER PROTECTION, CANNABIS, DATA PRIVACY, FIRE INSPECTIONS, CRIMINAL MISCHIEF AND ARTIFICIAL INTELLIGENCE.
*Effective June 2, 2026, except as otherwise noted*

**§ 9 — Background Checks for Homemaker-Companion Agency Employees**
This Section amends the homemaker-companion agency "comprehensive background check" definition by replacing the prior requirement for a "local" criminal background check with a state criminal background check. The national criminal background check component is retained.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

**§§ 39–43, 45 & 66 — Data Privacy Amendments**
*Effective October 1, 2026*

See the Public Act 26-64 summary below for the consolidated, reconciled discussion of the Data Broker Act amendments, surveillance-pricing repeal/replacement, and facial-recognition technology requirements as modified by Public Act 26-100.

16. PUBLIC ACT 26-143. AN ACT CONCERNING MEDICAID PROVIDER AUDITS.
*Effective October 1, 2026*

This Act amends the Medicaid provider audit statute to raise the threshold at which DSS may base an overpayment or underpayment finding on extrapolation. Under prior law, extrapolation was permitted when the total net extrapolated overpayment exceeded 1.75% of total claims paid to the provider for the audit period. The Act increases that threshold to 2.75% of total claims paid during the audit period. Additionally, beginning with audit review periods commencing January 1, 2027, DSS must make available up-to-date education materials and technical assistance documents to assist providers with proper Medicaid billing prior to extrapolation.

17. PUBLIC ACT 26-36. AN ACT ESTABLISHING AN ACCOUNT TO PROVIDE PATIENT LIFTS TO CERTAIN HEALTH CARE OFFICES AND FACILITIES.
*Effective July 1, 2026*

This Act establishes a separate, nonlapsing "health care facility patient lift account," administered by the State Treasurer. DPH may use the account to award grants for the purchase of patient lifts. Eligible grant recipients include physician offices, radiological facilities, imaging centers, hospitals, outpatient clinics, hospice facilities, nursing homes, residential care homes, home health and home health aide agencies, hospice agencies, assisted living services agencies, intermediate care facilities for individuals with intellectual disabilities and chronic disease hospitals. The lifts must be used to transfer elderly persons, persons with disabilities, and persons with injuries or chronic health conditions from facility beds to wheelchairs or other equipment. The account may receive appropriations, gifts, grants, donations, bequests and investment earnings. DPH may retain up to 2% of the account balance each FY for administrative costs, and no grant may exceed the available account balance.

18. SPECIAL ACT 26-12. AN ACT CONCERNING SUPPORTED DECISION-MAKING STUDY.
*Effective June 2, 2026*

This Act establishes a working group to study and make recommendations concerning supported decision-making. "Supported decision-making" is a process that allows an adult, defined as any person who is eighteen (18) years of age or older, to retain decision-making authority with assistance from one or more chosen supporters who help the decision-maker understand the nature and consequences of potential personal and financial decisions and communicate those decisions.



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*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
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*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

This process is intended to be memorialized through a "supported decision-making agreement" which is a voluntary written agreement between a decision-maker and one or more supporters that describes the types of decisions with which a supporter may help the decision-maker.

The working group must examine: (1) documentation needed for a decision-maker to conduct financial transactions with the assistance of a supporter; (2) how supporters can effectively assist alongside other legally recognized decision-makers in long-term care and other health care settings; (3) protection of health information under HIPAA, educational records under the Family Educational Rights and Privacy Act of 1974 ("FERPA"), and substance use disorder records under 42 CFR Part 2; (4) protecting decision-makers against a supporter's financial or ethical conflicts of interest; and (5) the use of supported decision-making agreements as an alternative to a conservatorship or guardianship. Unlike a conservatorship or guardianship, the supporter does not make decisions on the individual's behalf but rather assists the individual to understand and communicate their decisions.

The working group must include individuals representing hospitals, nursing homes, and physicians in private practice. Additionally, the working group will include a designee of the Probate Court and six individuals representing persons who may benefit from the use of supported decision-making agreements in making financial, health or other decisions. The General Assembly's Joint Committee on Public Health was required to hold the working group's first meeting on or before July 3, 2026, within thirty (30) days after the effective date of the Act. The first meeting was held on August 14, 2026.

The working group must submit a report and recommendations to the General Assembly's Joint Committees on Human Services, Government Oversight, Banking, Judiciary, and Public Health by December 31, 2026.

19. PUBLIC ACT 26-13. AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES.
*Effective October 1, 2026, except as otherwise noted*

This Act makes various revisions to the public health statutes. Following is a summary of the Sections of interest to providers of services to the elderly.

**§ 2 — MRC Working Group**
*Effective July 1, 2026*

This Section requires DPH to establish a working group regarding whether licensure of MRCs, where ALSA services are provided, would improve the health, safety and overall well-being of residents receiving ALSA services. The working group must include at least three (3) representatives of different MRCs, at least three (3) representatives of different ALSAs, three (3) residents receiving assisted living services in an MRC (one each from a different MRC), at least



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*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
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*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

three (3) relatives of such residents (one each from a different MRC), and a representative of an association of aging services organizations in the State. The working group must submit its findings and recommendations to DPH by January 1, 2027. DPH must then report those findings and recommendations to the General Assembly's Joint Committee on Public Health by February 1, 2027, including whether DPH agrees with each finding and recommendation.

**§ 4 — Patient Medical Records Retention and Access Notice**

This Section requires that by January 1, 2027, health care providers must provide each patient with written notice at the time of initial intake that informs the patient of (i) the length of time for which the provider is legally required to maintain patient medical records and (ii) the process for patients to request copies of their medical records from the provider. See Model Notice of Medical Record Retention, Access, and Copying Fees, attached at **Appendix C**.

**§§ 5-7 — Technical Changes**
*Effective May 14, 2026*

These Sections make technical changes to update the name of LeadingAge Connecticut, Inc. to LeadingAge Connecticut and Rhode Island, Inc.

**§§ 23, 24 & 27 — Nurse's Aides**

Section 23 expands the definition of "Nurse's Aide" to mean registered nurse's aides who provide nursing or nursing-related services at any licensed health care institution, rather than only those who provide services at nursing homes. The federal definitions of "abuse" and "neglect" have also been incorporated in this Section.

Section 24 amends C.G.S. § 20-102cc by expanding the categories of complaints that DPH may receive, investigate, and prosecute against nurse's aides to include "illegal, incompetent, or negligent conduct in the provision of nursing or nursing-related services." The amendment also broadens existing complaint grounds related to abuse, neglect, and misappropriation of property by extending them beyond residents to include patients and clients. In addition, the Section expands DPH's disciplinary authority to permit the summary suspension of a nurse's aide's ability to practice, prior to final adjudication of a complaint or during the appeal of a disciplinary finding, where DPH determines that the nurse's aide represents a clear and immediate danger to the public health and safety if allowed to continue practicing, pursuant to C.G.S. § 19a-17(c). This Section further authorizes DPH to impose any disciplinary sanction available under C.G.S. § 19a-17, including revocation, suspension, censure, issuance of a letter of reprimand, practice restrictions, or probation, upon a finding of good cause.



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*Wallingford, Connecticut 06492*
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*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

Section 27 makes conforming changes to nurse's aide training requirements by replacing references to "residents" with "patients" to reflect the broader applicability of the nurse's aide regulatory framework beyond nursing home residents.

**§§ 25-26 — Funds Received Under Rural Health Transformation Program**

Section 25 amends C.G.S. § 19a-17 to authorize DPH or the applicable licensing board or commission to take disciplinary action against a practitioner for failure to fulfill any material obligation resulting from the receipt of funds provided by DPH pursuant to the Rural Health Transformation Program established under 42 USC § 1397ee(h). This is only applicable to the organizations that bid and receive PACE contracts.

Section 26 amends C.G.S. § 31-57e to exempt the provision of funds to a tribe pursuant to the Rural Health Transformation Program established under 42 USC § 1397ee(h) from the State's prevailing wage requirements.

20. PUBLIC ACT 26-146. AN ACT CONCERNING A FIVE-YEAR MEDICAID RATE REVIEW, DENTAL REPRESENTATION ON A MEDICAL ASSISTANCE OVERSIGHT COUNCIL, BIOMARKER TESTING AND OPIOID PRESCRIPTION COVERAGE REQUIREMENTS AND A STUDY CONCERNING PAYMENT OF SPOUSES FOR STATE-SUBSIDIZED HOME CARE.
*Effective July 1, 2026, except as otherwise noted*

**§ 1 — Five-Year Medicaid Rate Review Process**

This Section requires DSS to create a five-year process for the regular and predictable review of Medicaid rates of reimbursement to (i) examine the rates paid to Medicaid providers and (ii) benchmark those rates to Medicare rates for the same services, when possible, under available appropriations. DSS must undertake the Medicaid rate review process by January 1, 2027. As part of the Medicaid rate review process, DSS may evaluate the rates paid in individual components of the Medicaid program. The evaluation of all Medicaid rates paid must be completed by January 1, 2032.

As part of this process, DSS may, in consultation with OPM, review and, subject to appropriated funds, increase and rebase rates at the end of each calendar year using an applicable, more current Medicare base year to strengthen access to care, improve quality and outcomes of care and reduce spending on acute care services. At the end of the five-year review process, DSS must commence a new review following the same schedule of evaluation and continue such reviews every five (5) years on an ongoing basis. As part of the review process, DSS must streamline and consolidate existing provider or service reimbursement fee schedules so that all providers are reimbursed for the same service using the same fee schedule, taking into consideration the most recent Medicare fee schedule for services covered by both Medicare and Medicaid, to the extent applicable.



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*Wallingford, Connecticut 06492*
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Also as part of the Medicaid rate evaluation process, DSS must develop a procedure to accept public comment, including written comments and oral comments at public meetings held by DSS and at meetings of the Council on Medical Assistance Program Oversight ("MAPOC"). By January 15, 2028, and annually thereafter, DSS must report to the General Assembly's Joint Committee on Appropriations and Human Services regarding the Medicaid rate evaluation process. The report must include recommendations on the level of appropriations necessary to increase compensation for Medicaid health care services providers, together with a description of the data and methodology used to develop those recommendations.

**§ 2 — Dental Representation on MAPOC**

This Section expands the membership of the Medical Assistance Program Oversight Council (MAPOC) to include a representative of DSS' Connecticut Dental Health Partnership's Dental Policy Advisory Council.

**§ 4 — Opioid Prescription Considerations for Medicaid Beneficiaries**

This Section requires practitioners who prescribe opioid medication to treat a Medicaid beneficiary's pain to consider whether nonopioid treatment options are feasible before prescribing opioids. Examples of nonopioid alternatives include chiropractic treatment, spinal cord stimulation, acupuncture and physical therapy. This legislation applies to physicians, dentists, podiatrists, optometrists, physician assistants, APRNs or nurse-midwives who are enrolled in Medicaid, are licensed by the State of Connecticut and are authorized to prescribe opioid drugs within their scope of practice. DSS is authorized to adopt regulations to implement these requirements.

**§ 5 — Working Group on Spousal Compensation for PCA Services**
*Effective June 2, 2026*

This Section establishes a working group to study the feasibility of allowing spouses to be compensated for PCA services for spouses who are enrolled in Medicaid home care programs. The working group must include the DSS commissioner or a designee, the Secretary of OPM or a designee, the House and Senate chairpersons of the General Assembly's Joint Committee on Human Services or a designee, and a consumer of PCA services and a provider organization representative.

The House and Senate chairs of the General Assembly's Joint Committee on Human Services shall appoint the members of the working group and designate its chairperson within thirty days after the section's effective date. The chairperson shall convene the first meeting of the working group within sixty days after the section's effective date. Staff of the Human Services Committee shall provide administrative support to the working group.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

The working group must submit a report on its findings and recommendations to the General Assembly's Joint Committee on Human Services by January 1, 2027. The working group will terminate on the date it submits the report or January 1, 2027, whichever is later.

21. PUBLIC ACT 26-84. AN ACT ESTABLISHING VARIOUS REQUIREMENTS REGARDING ELEVATORS.
*Effective October 1, 2026*

This Act establishes new maintenance, notification and enforcement requirements for elevators in "residential elevator buildings." The term is defined as any building located in the State that is wholly or partly used for residential purposes with at least one elevator used as the means of ingress and egress to any floor above or below the ground floor, including a garage. The definition excludes buildings on municipal-owned or state-owned property and buildings undergoing remodeling, restoration, repair or renovation under a current building permit.

***Although the definition is broad, there is a strong argument that this provision was not intended to apply to DPH-licensed health care institutions, such as nursing homes and residential care homes.*** Those facilities are subject to DPH licensure and physical plant/life safety oversight, rather than being regulated solely as ordinary residential buildings through local building authority enforcement. The structure of the Act also appears to contemplate enforcement by local building officials and the Department of Administrative Services (DAS) in the context of residential elevator buildings, which supports the view that the provision is aimed primarily at residential housing settings rather than licensed health care facilities. However, because the statutory definition does not expressly exclude DPH-licensed facilities, providers should monitor any implementing guidance from DAS, DPH or local building officials.

Owners of residential elevator buildings must: (1) maintain each elevator in continuous working order in accordance with applicable building and housing codes, including the Connecticut Safety Code for Elevators and Escalators; (2) post permanent signage in English and Spanish as close as possible to the elevator's call buttons, but not higher than sixty inches from the floor, stating:

> **"If this elevator is not working and it is an emergency, dial 911. If it is not an emergency and you do not have access to another working elevator for at least forty-eight consecutive hours, call (THE APPLICABLE MUNICIPALITY) at (THE APPLICABLE PHONE NUMBER)."**

(3) provide tenants at least twenty-four (24) hours' notice of scheduled maintenance; and (4) within 24 hours after an elevator is reported as inoperable and not restored to service, provide written notice to each affected tenant identifying the cause (if known), estimated restoration time, a contact for status updates and the local building official's contact information. See Model Elevator Notice to Tenants, attached at **Appendix D**.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

If an elevator remains inoperable for forty-eight (48) hours, the owner must submit to the local building official the notice provided to tenants within twenty-four (24) hours of inoperability and a repair plan prepared by a licensed elevator contractor. Local building officials must investigate complaints, issue compliance requests, notify the Department of Administrative Services of inoperability events, complaints and noncompliance, and may require more frequent inspections or revocation of the certificate to operate. The Department of Administrative Services may impose a penalty of up to $250 for a first offense and up to $500 for each subsequent offense.

22. PUBLIC ACT 26-6. AN ACT CONCERNING CREDIT CARDS AND HEALTH AND VETERINARY CARE SERVICES.
*Effective January 1, 2027*

This Act regulates the relationship between health care providers and third-party financing. Third-party financing is defined as any line of credit or loan offered or extended by a third party and excludes any line of credit or loan offered or extended by the health care provider in which the provider is the creditor. Effective January 1, 2027, no health care provider may: (i) advertise or offer third-party financing using the provider's branding, or provide consumers with branded access to a third-party financing website; (ii) advertise or offer third-party financing while the consumer is under anesthesia, sedation or nitrous oxide, while providing health care services, or while the consumer is in any area of a facility used to provide health care services (unless the facility has no separate area); (iii) receive financial incentives in exchange for advertising third-party financing; (iv) complete or submit a third-party financing application on behalf of a consumer; (v) charge a third-party financing account for a health care service before it is provided (unless the cost has already been incurred); or (vi) charge a third-party financing account for ancillary products without a receipt or separate written consent.

Providers that discuss terms and conditions of third-party financing with consumers must provide a detailed, written disclosure with specific wording set forth in the Act, in at least 14-point type, and in the consumer's primary language, explaining that such financing is not a payment plan with the provider, that the consumer is not required to apply, and that missed payments may affect credit scores or result in legal action. Although credit cards, as well as payment plans, are considered third-party financing, the Act states that if a provider accepts a credit card (or other third-party financing) as a form of payment but does not discuss the terms and conditions of the third-party financing, the provider does not have to provide the disclosure.

Violations of this provision will constitute unfair or deceptive trade practices enforceable solely by the Attorney General.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

23. PUBLIC ACT 26-56. AN ACT CONCERNING RETURN OF HEALTH CARE PROVIDER PAYMENTS.

*Effective January 1, 2027*

This Act strengthens protections for individual licensed health care practitioners and group practices against insurer payment cancellations and denials, as well as recoupment of previously paid claims. Section 1 amends C.G.S. § 38a-479b to (1) reduce the lookback period for canceling, denying or demanding return of payment for an authorized covered service due to administrative or eligibility error from eighteen (18) months to twelve (12) months after receipt of a clean claim and (2) require that the thirty (30)-day notice of cancellation, denial or demands for full/partial refund of any payment to a provider must be given by certified mail, designated email, fax, or through a secure electronic provider portal or electronic clearinghouse. Section 1 also amends the provision for provider appeals of any payment cancellations, denials or refund demands to state that the appeals process may include, but need not be limited to, an electronic appeals process. In addition, it provides that if the health insurer fails to respond to the appeal within thirty (30) business days of receipt, the appeal must be construed in the provider's favor.

Section 2 establishes payment protections for health care providers under specified individual and group health insurance policies issued, renewed, amended or continued in Connecticut. It generally prohibits insurers, health care centers, fraternal benefit societies, hospital service corporations, medical service corporations and other covered entities from canceling, denying or demanding the return of full or partial payment for an authorized covered service due to an administrative or eligibility error more than twelve (12) months after receipt of a clean claim.

The twelve (12)-month limitation does not apply when there is a documented basis to believe that the claim was submitted fraudulently; the provider billed inconsistently with the services actually provided; the claim was paid more than once; the claim should have been or was paid by a federal or state program; or the provider received payment from another insurer, payor or administrator through coordination of benefits or subrogation, automobile insurance or workers' compensation coverage. When the cancellation, denial or recoupment involves payment from another source, the provider has one (1) year to submit an adjusted secondary-payor claim, regardless of the insurer's timely-filing requirements.

Covered insurers must provide the provider with at least thirty (30) days' advance notice of a payment cancellation, denial or recoupment demand by certified mail, designated email, fax, secure electronic provider portal or electronic clearinghouse used for claims or remittance communications. A repayment demand must identify the amount to be returned, the affected claim and the basis for the demand.

The provider may appeal within thirty (30) days after receiving the notice, and the insurer's appeal procedures must include an electronic appeal process. If the insurer does not notify the provider of



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

its decision within thirty (30) business days after receiving the appeal, the appeal must be construed in the provider's favor. Any demand for repayment is stayed while the appeal is pending.

If the provider does not appeal or the appeal is denied, the provider generally may submit an adjusted claim within thirty (30) days after receiving the notice or denial, except when repayment was demanded because the claim was paid more than once. The provider also has one (1) year after the written notice to identify other insurance coverage applicable on the date of service and file a claim with that insurer or other issuing entity, regardless of its timely-filing requirements.

## IV. MISCELLANEOUS PUBLIC ACTS

24. PUBLIC ACT 26-64. AN ACT CONCERNING CONSUMER PRIVACY AND PROTECTION.
*Effective October 1, 2026*

**§§ 1–10 — Data Broker Registration and Accessible Deletion Mechanism**

These Sections established Connecticut's Data Broker Registration and Accessible Deletion Mechanism Act, but Public Act 26-100 later amended several of the provisions and repealed two sections in Public Act 26-64. Accordingly, this summary describes the Public Act 26-64 framework as modified by Public Act 26-100.

The Act regulates "data brokers," meaning businesses that sell or license brokered personal data to another person. Brokered personal data includes specified identifying elements such as name, address, date and place of birth, mother's maiden name, certain unique biometric data used to identify or authenticate a consumer, family or household member information, Social Security or other government-issued identification numbers, and other information that, alone or with other sold or licensed information, would allow a reasonable person to identify the consumer with reasonable certainty. Public Act 26-100 removed the separate "data service provider" concept from the Act.

***Note that as amended by Public Act 26-100, the Data Broker Act has several exemptions, including an exception for HIPAA covered entities, business associates or protected health information, and businesses that collect information about consumers with whom they have a contractual, investor, donor or similar relationship***. It also excludes agents or service providers acting for those exempt businesses or governmental entities. However, non-HIPAA marketing, fundraising, website-user, prospect-list, geolocation, biometric or consumer-profile data that are sold or licensed to another person may still require separate analysis.

Section 2 requires any data broker intending to sell or license brokered personal data in Connecticut on or after January 1, 2027 to register with DCP ($2,500 initial and annual renewal



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

fee). Registration applications must disclose whether the broker collects minors' data or precise geolocation, reproductive or sexual health data, and describe measures to prevent unlawful sales.

Section 3 prohibits data brokers from selling or licensing personal data in violation of the Act or the Connecticut Data Privacy Act (CDPA) and requires each registered broker to maintain a privacy policy.

Section 4 requires DCP to maintain a public webpage listing registered data brokers and providing access to the deletion mechanism.

Section 5 establishes the accessible deletion mechanism program, which DCP must establish by July 1, 2028. As amended by Public Act 26-100, consumers may submit deletion requests without charge in English, Spanish and any other language spoken at home by at least 1% of Connecticut's population, based on the most recent decennial census. Consumers must submit information sufficient to establish Connecticut residency, rather than being limited to a motor vehicle operator's license number. Beginning October 1, 2028, registered data brokers must access the mechanism at least once every forty-five (45) days, determine whether they have been excluded from a deletion request, and delete personal data for verified requests unless a statutory exception applies. Extensive exceptions permit retention or use for legal compliance, regulatory inquiries, law enforcement cooperation, legal claims, requested services, contract performance, safety, security, fraud prevention, certain research, internal operations and other specified purposes. Registered data brokers must undergo independent compliance audits triennially beginning July 1, 2031.

Section 6 requires annual public transparency reports (beginning July 1, 2029) disclosing the number of deletion requests received and the broker's responses.

Sections 8 through 10 address administration and enforcement. Section 8 creates a separate, nonlapsing data broker registration account, funded by data broker registration fees, deletion-mechanism access fees and civil penalties, to support DCP's administration of the accessible deletion mechanism program. Section 9 authorizes DCP to adopt implementing regulations for the registration, exemption, deletion-mechanism and related compliance provisions. Section 10, as amended by Public Act 26-100, authorizes DCP, after notice and hearing, to impose civil penalties of up to $200 per day per consumer for each violation of Sections 2 through 8. Because the penalty is calculated per day and per consumer, potential exposure could increase quickly for a registered data broker that fails to register, maintain required disclosures, access the deletion mechanism, process deletion requests, comply with audit obligations or otherwise meet the Act's requirements.

**§§ 12–16 — Amendments to the Connecticut Data Privacy Act (CDPA)**

Section 12 amends the definitions in C.G.S. § 42-515, including: adding a new definition of "facial recognition technology" (technology that analyzes facial features to uniquely identify an



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

individual); revising "publicly available information" to remove the requirement that government records be "lawfully" available and to add exclusions for biometric data collected without consumer knowledge, genetic data, information posted with a reasonable expectation of privacy, and nonconsensual intimate images; and prohibiting the sale of precise geolocation data.

Section 13 expands consumer rights under C.G.S. § 42-518 to include: the right to delete publicly available information that has been collated to create a consumer profile or made available for sale (and any inferences derived therefrom); the right to question automated profiling decisions that produce legal or similarly significant effects; and the right to obtain a list of third parties to which the controller has sold the consumer's personal data.

Section 14 amends controller duties under C.G.S. § 42-520 to: replace the "material purpose" standard with a "new purpose" standard (prohibiting processing for any new purpose that is neither reasonably necessary to nor compatible with disclosed purposes without consent); prohibit the sale of sensitive data without consent; prohibit targeted advertising or sale of personal data for consumers aged 13–17; and prohibit the sale of any consumer's precise geolocation data.

Section 15 amends processor duties under C.G.S. § 42-521 to prohibit third parties from selling any consumer's precise geolocation data.

Section 16 originally amended C.G.S. § 42-524 to add facial recognition technology requirements, but Public Act 26-100 repealed Public Act 26-64 § 16 and replaced it with the revised facial-recognition language summarized above in Public Act 26-100 § 45. Members using facial recognition technology should therefore follow the Public Act 26-100 § 45 summary.

**§ 16 — Facial Recognition Technology Requirements Repealed and Replaced by Public Act 26-100 § 45**

Public Act 26-64 originally amended C.G.S. § 42-524 to add facial recognition technology requirements, but Public Act 26-100 repealed Public Act 26-64 § 16 and replaced it with revised facial-recognition language in Public Act 26-100 § 45. These requirements are separate from the Data Broker Act, so the Data Broker Act exemptions described above do not automatically determine whether the facial recognition requirements apply. As revised, the requirements apply to a controller or consumer health data controller subject to the CDPA that uses facial recognition technology on its premises for security-related purposes, including to prevent, detect, protect against or respond to security incidents, identity theft, fraud, harassment, malicious or deceptive activity, illegal activity, system-integrity or system-security issues, or related investigations. "Facial recognition technology" means technology that analyzes facial features in still images or video to uniquely and personally identify a specific individual.

HIPAA covered entities, business associates and PHI are generally exempt from the CDPA. If facial recognition is used for treatment or another HIPAA-regulated purpose involving PHI, the



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

CDPA exemption may be relevant. If it is used for building access, visitor management, security monitoring, loss prevention or similar non-treatment purposes, the organization should separately analyze whether the CDPA facial-recognition requirements apply. Ordinary video surveillance that records images but does not analyze facial features to uniquely identify specific individuals should not, by itself, trigger this facial-recognition provision.

A controller is the person or organization that determines the purpose and means of processing personal data. A consumer health data controller is a controller that determines the purpose and means of processing consumer health data, which generally means personal data used to identify a consumer's physical or mental health condition, diagnosis or status. A controller or consumer health data controller subject to these requirements must use facial recognition technology only to match still images or video against a database maintained exclusively by that controller or consumer health data controller. It must also post clearly legible signage at each public entrance to the premises where the technology is used, other than entrances to employee-only restricted areas. The signage must alert consumers that facial recognition technology is in use and include a conspicuous hyperlink or QR code directing consumers to the organization's facial recognition technology policy. The policy must include contact information for the Office of the Attorney General and may describe the organization's policies concerning interactions between loss-prevention officers and consumers.

Public Act 26-100 also adds an exception: the signage and policy requirements do not apply with respect to a consumer if the controller or consumer health data controller has obtained that consumer's consent to use facial recognition technology in the course of a commercial transaction.

**§§ 17–19 — Direct-to-Consumer Genetic Testing and Genetic Data Protections**

Sections 17–19 establish new protections for genetic data, but they apply specifically to direct-to-consumer genetic testing companies. A direct-to-consumer genetic testing company is a person or company doing business in Connecticut that, in the ordinary course of business, offers genetic testing directly to consumers or collects, uses or analyzes genetic data that a consumer provides. The definition does not include an individual licensed in Connecticut to provide health care services who, while acting within the scope of that professional practice, orders genetic testing for a medical purpose.

Covered direct-to-consumer genetic testing companies must recognize that consumers have a property right in their biological samples and genetic testing results. They must obtain express consent before collecting, using or disclosing genetic data; must obtain separate consent for certain disclosures, secondary uses and retention of biological samples; may not disclose genetic testing results except with consent or pursuant to court order, warrant or subpoena; may not disclose genetic data to employers, insurers or third parties for marketing, including targeted advertising; must implement reasonable security measures; and must provide processes for consumers to access



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

genetic data, require deletion, require destruction of biological samples and revoke research-related consent. Violations are enforceable solely by the Attorney General as unfair or deceptive trade practices.

25. PUBLIC ACT 26-15. AN ACT CONCERNING ONLINE SAFETY.
*Effective October 1, 2026, except as otherwise noted*

**§§ 4-6 — Artificial Intelligence Companion Safety Requirements**
*Effective January 1, 2027*

These Sections regulate "artificial intelligence companions," defined in Section 4 as artificial intelligence models or systems with a natural language interface that provides adaptive, human-like responses to user inputs and can sustain a relationship across multiple interactions. Excluded from this definition are chatbots used only for a business's operational purposes, internal research, technical assistance, customer service or support, assisting or supporting patient or resident care services in a facility, or stand-alone consumer electronic devices that function as a speaker and voice-activated virtual assistant. Also excluded are any artificial intelligence system used solely to provide health care-related education, clinical support, medication-adherence reminders, disease-management guidance or other treatment-support functions, provided such artificial intelligence system does not present itself as a human being, does not use anthropomorphic features, and is not designed to meet a user's social or emotional needs. Further excluded are any narrow, task-specific tool that provides outputs relating to a discrete topic or function, provided the primary function of such tool is not to discuss topics related to mental health.

Effective January 1, 2027, no operator shall provide to a user or operate for a user, an artificial intelligence companion unless the companion includes a protocol that uses evidence-based methods to (i) detect any user expression clearly indicating a risk of suicide, self-harm, or imminent physical violence, and (ii) institute measures to prevent the companion from generating any output that encourages suicide, self-harm or physical violence. If the artificial intelligence companion detects any user expression indicating risk of suicide, self-harm or imminent physical violence, it must refer the user to appropriate mental health evaluation and treatment services, including the National Suicide Prevention Lifeline, if applicable. The operator must also post the protocol used to detect suicide, self-harm or imminent physical violence in a prominent and publicly accessible location on the operator's website. The term "operator" is defined under these sections as any individual, business entity or affiliate, member, subsidiary or beneficial owner of a business entity who provides an artificial intelligence companion to, or operates an artificial intelligence companion for, a user.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

The operator must implement reasonable measures to prohibit and prevent the artificial intelligence companion from claiming that the artificial intelligence companion is a human being or generating any output that refutes or conflicts with any disclosure that the artificial intelligence companion is not a human being. If an artificial intelligence companion would cause a reasonable individual to believe that they are interacting with another human being and not an artificial intelligence companion, the operator of the artificial intelligence companion must provide clear and conspicuous notice that the user is communicating with an artificial intelligence companion. This notice must be provided to the user in static written form visible throughout the interaction between the user and the artificial intelligence companion, and in an audible or written form at the beginning of the first interaction between the user and the artificial intelligence companion during any twenty-four (24) hour period and at least once during each three (3) hour-period of continuous artificial intelligence companion interaction.

Any violation of these provisions constitutes an unfair or deceptive trade practice under C.G.S. § 42-110b to be enforced exclusively by the Attorney General.

**§§ 7-14 — Automated Employment-Related Decision Technology**

These Sections establish new requirements governing the use of automated employment-related decision technology in the State. "Automated employment-related decision technology" is defined as any technology that processes personal data and uses computation to generate output that is a substantial factor used to make or materially influence an employment-related decision, including decisions to hire, promote, discipline or discharge an individual. Excluded from this definition is any word processing, spreadsheet, map navigation, web hosting, domain registration, networking, caching, Internet web site loading, data storage, firewall, anti-virus, anti-malware, spam and robocall filtering, spellchecking, calculator, database, or similar software or technology as long as such software or technology does not make or materially influence an employment-related decision. Also excluded from the definition of automated employment-related decision technology is any system or service that is used in a manner that is incidental to making an employment decision or any information that is purely descriptive, diagnostic or statistical in nature and not relied upon to make or materially influence an employment-related decision.

An “employment-related decision” is any decision made based on that individual’s personal data to hire, promote, discipline, or discharge an individual; to renew the individual’s employment; to select the individual for any training or apprenticeship; or with respect to the individual’s tenure or terms, privileges or conditions of employment. Decisions that result in any nonmaterial change in an individual’s job task, work responsibilities, hours, or work assignments, or are made with respect to workplace health and safety, scheduling and planning, or productivity monitoring are excluded from the definition of an employment-related decision.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

On or after October 1, 2027, a "deployer" who deploys automated employment-related decision technologies that are intended to interact with an employee or applicant for employment in the state must ensure that it is disclosed to each employee or applicant, in plain language, that they are interacting with automated employment-related decision technologies. The Act defines "deployer" as a person doing business in the state who deploys an automated employment-related decision technology in the state, and a "developer" as a person doing business in the state who develops, or intentionally and substantially modifies, an automated employment-related decision technology.

Such disclosure is not required if it would be obvious to a reasonable person that they are interacting with automated employment-related decision technology.

On or after October 1, 2027, a deployer who deploys an automated employment-related decision technology to generate any output for the purpose of making, or as a substantial factor in making, an employment-related decision concerning an employee or applicant for employment in the state must provide to the employee or applicant, before the employment-related decision is made, a written notice disclosing the deployment of an automated employment-related decision technology. This notice must include the purpose of the technology, the nature of the employment-related decision, the trade name of the technology, the categories and sources of personal data concerning the employee or applicant to be analyzed by the decision technology and how that data will be assessed in reaching a decision, and contact information for the deployer.

No provision of these sections shall be construed to require any person to disclose any information that is a trade secret or otherwise protected from disclosure under state or federal law. If a person withholds any such information, they must send a notice to the person they are withholding information from, disclosing that information is being withheld and the basis of the decision to withhold that information. Any violation of the provisions of these sections shall constitute an unfair and deceptive trade practice under C.G.S. § 42-110b and shall be enforced solely by the Attorney General.

**§ 26 — Layoff Disclosure Requirements Related to Artificial Intelligence**

This Section requires each employer that serves written notice regarding layoffs to the Labor Department pursuant to the federal Worker Adjustment and Retraining Notification Act (29 USC § 2102(a)) to disclose to the Labor Department whether the layoffs that are the subject of such notice are related to the employer's use of artificial intelligence or another technological change.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

26. PUBLIC ACT 26-73. AN ACT CONCERNING THE ELECTRONIC SURVEILLANCE OF EMPLOYEES.
*Effective October 1, 2026*

This Act amends C.G.S. § 31-48d, Connecticut's electronic monitoring notice statute. Existing law generally requires an employer that engages in electronic monitoring of employees to provide prior written notice of the types of monitoring that may occur and to post a notice in a conspicuous place readily available to employees. The Act expands those notice requirements by requiring the notice to identify the specific locations on the employer's premises where electronic monitoring may occur. The required posted notice must still be placed in a conspicuous location readily available to employees, and the Act clarifies that the posting location must include, but need not be limited to, the specific location on the employer's premises where the monitoring may occur. The Act also requires employers to provide each employee hired on or after October 1, 2026, before the employee begins work, with a plain-language written statement identifying activities that are prohibited and that may be monitored without additional prior written notice. The Act includes an exception to the location-specific notice requirement where the employer has reasonable grounds to conduct electronic monitoring for security and employee safety purposes.

27. PUBLIC ACT 26-145. AN ACT CONCERNING CENTRALIZATION OF WORKFORCE DEVELOPMENT INFORMATION.
*Effective October 1, 2026*

This Act directs the Labor Commissioner to create, by January 1, 2027, a centralized workforce development web page on the Department of Labor's website. The web page must serve as a repository of information, resources, and materials regarding job training, career counseling, workforce development organizations and opportunities, regional sector partnerships, and other workforce development topics. The Commissioner must update the page on a semiannual basis.



*LeadingAge Connecticut & Rhode Island, Inc.*
*110 Barnes Road*
*Wallingford, Connecticut 06492*
*(203) 678-4477*
*www.leadingagectri.org*

*Wiggin and Dana LLP*
*One Century Tower*
*New Haven, Connecticut 06508*
*(203) 498-4400*
*www.wiggin.com*

Appendix A

# Memorandum

To: LeadingAge Connecticut and Rhode Island

From: Wiggin and Dana LLP

Date: August 13, 2026

**Re: Resident Use of Virtual Monitoring and Recording Devices**

The rules for resident cameras, video doorbells, audio/video devices, and other recording technology are not the same across all long-term care settings. The bill of rights for residents of nursing homes, residential care homes ("RCHs"), chronic disease hospitals, and managed residential communities ("MRCs") establishes the resident's basic right to treat his or her living quarters in these settings as his or her home, including the right to purchase and use technology of the resident's choice such as technology to facilitate virtual visitation, so long as operation and use of the technology does not violate any individual's right to privacy under state or federal law.[1]

However, Connecticut also has facility-specific laws governing when and how residents of nursing homes, and, effective October 1, 2026, RCHs, may use virtual monitoring technology. There is currently no comparable Connecticut statute specifically governing resident-owned monitoring technology in MRCs, although MRC residents have technology rights under the MRC bill of rights and MRCs remain subject to landlord-tenant principles and general privacy laws.

The requirements applicable to each provider type are summarized below.

## I. NURSING HOMES

### a. Rights and Rules for Residents and Their Representatives

Pursuant to Conn. Gen. Stat. § 19a-550b, nursing home residents have the right to use technology of their choice for virtual monitoring or virtual visitation in their room, subject to certain conditions and requirements. According to the statute, "virtual monitoring" means remote monitoring of a

[1] The bill of rights for residents or nursing homes, residential care homes, and chronic disease hospitals is at Conn. Gen. Stat. § 19a-550. The bill of rights for managed residential community residents is at Conn. Gen. Stat. § 19a-697.

resident by a third party via technology owned and operated by the resident in the resident's room or living quarters and "virtual visitation" means remote visitation between a resident and family members or other persons with technology. Cell phones used primarily for calls and tablets not used for virtual monitoring are exempt from the statutory requirements, although they still may not be used in a way that violates anyone's privacy rights.

If the resident is not capable of exercising this right, a "resident representative" may do so on the resident's behalf. The statute defines a "resident representative" as a court appointed conservator of the person or guardian or an appointed health care representative; if there is no conservator of the person or health care representative, then a person whom the resident has designated in a written document signed by the resident and included in the resident's records on file at the facility may serve as the resident's representative, and if there is no such written document, a legally liable relative or other responsible party can act on the resident's behalf.

If a resident or resident's representative wishes to install and use technology for virtual visitation or monitoring, the following requirements apply:

- **Resident Responsible for Expenses.** The resident is responsible for all costs associated with the technology, including its purchase, installation, activation, maintenance, repair, operation, deactivation, and removal.

- **No Privacy Right Violations.** The technology and any recordings and images obtained must only be used by the resident and any person communicating with the resident or monitoring the resident, in a manner that does not violate any individual's rights under state or federal law.

If virtual monitoring is employed, the following are also required:

- **Posted Notice of Monitoring.** A clear and conspicuous notice must be placed on the door of the resident's room or living unit indicating that such technology may be in use.

- **Detailed Notice to Roommate(s).** If the resident has a roommate, the resident must give the roommate or representative of the roommate advance notice describing the type of technology, its location, its intended use, its hours of operation, and whether it has recording or remote-activation capabilities.

- **Written Consent from Roommate(s).** The resident must obtain written consent from all roommates before activating virtual monitoring technology; if a roommate later withdraws consent, the resident must stop using the technology for monitoring until consent is restored and must notify the facility in writing within seven days of the withdrawal.

- **Written Notice to Nursing Home.** At least seven days before installing or using virtual monitoring technology, the resident must file a signed written notice with the facility, accompanied by any required roommate consent form, identifying the type of technology and how it will be used, its hours of operation, its location in the room, whether it has

recording or remote-activation capabilities, an acknowledgment of the resident's financial responsibility, and a waiver of liability for the facility. The Connecticut Long Term Care Ombudsman Program developed model consent forms for residents and roommates that can be used, accessible here.

**b. Nursing Home Responsibilities**

- **Internet Access**. The nursing home must provide internet access, electricity, and a power source for virtual monitoring or visitation technology at no cost to the resident. However, the nursing home must include the cost of providing internet access in cost reports filed with the Department of Social Services for purposes of Medicaid reimbursement. The cost is reimbursable to the facility only if the Department of Social Services determines it is eligible for reimbursement. The nursing home may assess a prorated portion of any unreimbursed cost of internet upgrades to a privately paying resident using the technology. A resident is also permitted to procure his or her own internet connectivity. In that case, the nursing home may not charge the resident for any cost of facility internet infrastructure upgrades necessary for resident use of technology.

- **Facility Notice.** The nursing home must place a conspicuous notice (i) at the entrance to the facility indicating that technology enabling virtual monitoring or virtual visitation may be in use in some residents' rooms and (ii) on the door of any resident's room where technology will be used for virtual monitoring.

- **Roommate Refusal of Consent.** If a roommate refuses to consent to virtual monitoring, the nursing home must work with both residents to try to reach an acceptable accommodation. If the roommate continues to refuse consent, the nursing home must help the resident who wishes to use the technology find an alternative, such as a transfer to a room with a consenting roommate, if one is available; the resident may be responsible for any difference in cost associated with such a transfer.

- **Policies.** The statute permits a nursing home to establish policies and procedures on use of technology for virtual monitoring, addressing the following areas:

    - **Placement of the technology.** Facility policy and procedures may require that any technology device be placed in a conspicuously visible, stationary location in the resident's room (but such a requirement does not apply to cellular mobile telephones used primarily for telephone communications or tablets not used for virtual monitoring).

    - **Restrictions on location of video/audio recordings.** Policies and procedures may place restrictions on use of technology to record video or audio outside the resident's room or in any shared common space.

- **Compliance with life safety code/fire protection requirements.** The policies may also require that the installation, placement and use of technology comply with applicable life safety code and fire protection requirements.

- **Privacy.** The nursing home may address limitations on use of technology for virtual monitoring in its policies and procedures when such use will interfere with resident care or privacy, unless the resident, roommate or his or her resident representative consents to such use.

- **Internet service disruption.** The policies and procedures may provide that the nursing home can limit the use of technology in the event of a disruption to the facility's internet service.

### c. Nursing Home Immunity

Conn. Gen. Stat. § 19a-550b currently provides nursing homes with immunity from civil, criminal, or administrative liability in specified circumstances. Public Act 26-28 amends that immunity provision effective October 1, 2026, as described below:

- **Privacy Right Violations.** The facility is immune from such liability for violations of privacy rights of any individual under state or federal law that is caused by a resident's use of technology. Effective October 1, 2026, PA 26-28 § 2 narrows this provision by removing the reference to federal law, so that statutory immunity will apply to violations of privacy rights under state law only.

- **Damage to Resident's Technology.** The nursing home is also immune from liability for damage to the resident's technology, including but not limited to any malfunction not caused by the facility's negligence. Effective October 1, 2026, PA 26-28 § 2 revises this standard so that immunity will not apply where the damage or malfunction was caused intentionally or negligently by the nursing home.

- **Use, Interception or Disclosure.** Immunity protection also extends to situations in which audio or video produced by the resident's technology is inadvertently or intentionally disclosed to, intercepted or used by an unauthorized third party. Effective October 1, 2026, PA 26-28 § 2 adds an important limitation: the immunity applies only if the nursing home did not intentionally cause the audio or video to be disclosed to, intercepted, or used by the unauthorized third party.

## II. RESIDENTIAL CARE HOMES

RCH residents already have a general bill of rights protection under Conn. Gen. Stat. § 19a-550, which includes the right to treat their living quarters as their home and to purchase and use technology of the resident's choice, including technology to facilitate virtual visitation, so long as the operation and use of the technology does not violate any individual's privacy rights under state or federal law. Public Act No. 26-28, effective October 1, 2026, establishes a new, RCH-

specific framework for resident-owned technology used for virtual monitoring, defined as remote monitoring of a resident by a third party through technology owned and operated by the resident in the resident's room or living quarters. Unlike the nursing home statute, which separately addresses both virtual monitoring and virtual visitation, the new RCH statute addresses virtual monitoring only; RCH residents' broader right to use technology for virtual visitation continues to arise from the existing RCH bill of rights.

In general, the new RCH framework tracks most of the requirements discussed above for nursing homes. For example, an RCH resident or resident representative who wishes to use virtual monitoring technology must provide advance notice to roommates, obtain required written roommate consent, give the RCH signed written notice at least seven days before installing or using the technology, identify the type, location, intended use, hours of operation, and recording or remote-activation capabilities of the technology, acknowledge the resident's financial responsibility for the technology, provide the required liability waiver, and stop using the technology if roommate consent is withdrawn until consent is obtained again.

The statute also permits, but does not require, an RCH to adopt policies and procedures addressing the same general operational issues addressed in the nursing home statute, including device placement, restrictions on recording outside the resident's room or living quarters or in shared spaces, compliance with life safety and fire protection requirements, interference with resident care or privacy, internet service disruptions, and consequences and appeal rights for noncompliance.

However, Public Act No. 26-28 does not import the following affirmative facility obligations that apply to nursing homes:

- **No Facility Obligation to Provide Internet Access, Electricity, or a Power Source.** Unlike the nursing home statute, the RCH statute does not require the RCH to provide internet access, electricity, or a power source for monitoring technology at no cost to the resident.

- **No Facility Entrance Notice Requirement.** The RCH statute requires a clear and conspicuous notice on the door of the resident's room or living unit when virtual monitoring technology may be in use, but it does not require the RCH to post a facility-wide entrance notice stating that monitoring or visitation technology may be in use in some residents' rooms.

- **No Roommate Accommodation or Transfer Process Imposed on the RCH.** The nursing home statute requires the facility to work with residents when a roommate refuses consent and, if necessary, assist with an alternative room placement if available. The RCH statute does not include that facility obligation. Instead, if roommate consent is withdrawn, the resident must cease using the monitoring technology until consent is obtained and must notify the RCH in writing within seven days.

Public Act No. 26-28 authorizes the Office of the Long-Term Care Ombudsman to develop standard forms for resident notice to the RCH, roommate consent, and notice of withdrawal of

roommate consent. As of the date of this memorandum, those RCH-specific forms have not yet been issued. Unless and until such forms are published, RCHs should use forms that incorporate the statutory requirements set forth in PA 26-28.

Finally, the Act provides RCHs with immunity protections that parallel the nursing home immunity provisions as amended by Public Act No. 26-28. An RCH is immune from civil, criminal, and administrative liability for privacy rights violations under state law caused by a resident's use of technology in accordance with the statute; damage to the resident's technology, including malfunction, unless caused intentionally or negligently by the RCH; and unauthorized disclosure, interception, or use of audio or video produced by the resident's technology, provided the RCH did not intentionally cause the disclosure, interception, or use.

## III. MANAGED RESIDENTIAL COMMUNITIES

MRCs, including those that provide services through an assisted living services agency, are subject to Connecticut landlord-tenant laws. Although MRCs are not governed by facility-specific virtual monitoring and visitation statutes comparable to those applicable to nursing homes and RCHs, they remain subject to Connecticut privacy laws.

Pursuant to Conn. Gen. Stat. § 19a-697(a)(5), MRC residents have the right to associate and communicate privately with persons of the residents' choice, and the right to purchase and use technology of the residents' choice, including technology that may facilitate virtual visitation with family and others, provided that its operation and use does not violate any individual's right to privacy under state or federal law. However, there is neither a statutory notice-and-consent framework comparable to nursing homes and RCHs, nor a statutory immunity provision protecting the MRC from liability related to a resident's use of such technology.

An MRC has more limited authority to regulate monitoring technology used solely inside a resident's private unit than it has in common areas. Any restrictions inside the unit should be tied to the residency agreement or lease, applicable landlord-tenant principles, community rules, property alteration or installation requirements, staff access rights, operational concerns, and the bill-of-rights limitation that technology may not be used in a way that violates another person's privacy. MRC operators should ensure that residency agreements and community rules address camera and monitoring use in a manner consistent with these rights. For example, a resident's camera in the resident's own unit does not eliminate the MRC's right of entry for inspections or maintenance under the lease, and vice versa.

In common or shared spaces, such as hallways, dining rooms, activity rooms, and lobbies, the community's property is not the resident's private home, and the MRC retains significantly greater authority to control or prohibit resident-owned recording devices through community policies and rules. This distinction is particularly important for video doorbells or similar devices installed at or near the entrance to a resident's unit. Although the inside of the unit is the resident's private living space, a video doorbell typically records the hallway, corridor, or other shared area outside the unit. Because those areas are not part of the resident's exclusive living space, an MRC has a stronger basis to regulate or prohibit resident-installed video doorbells through its residency

agreement, lease, or community rules, particularly where the device records other residents, staff, visitors, or common areas.

## IV. GENERAL CONNECTICUT PRIVACY AND RECORDING LAWS

Providers should understand that the facility-specific rules discussed above do not give residents unlimited permission to record. Those rules address when resident-owned technology may be used in a resident's room or unit for virtual monitoring or visitation. General Connecticut privacy and recording laws still apply to recordings and uses of recordings that go beyond that framework. For example:

- **Common Area Recording May Be Restricted.** Resident-owned technology should not record hallways, dining rooms, activity areas, lobbies, entrances, or other shared spaces unless permitted by facility policy and applicable law. This is especially relevant for video doorbells and similar devices that are installed at a resident's door but record outside the resident's private room or unit.

- **Telephone Calls and Similar Private Communications are Different.** The virtual monitoring and visitation laws do not authorize recording private telephone calls without satisfying applicable consent requirements. Connecticut requires all-party consent before recording a private telephone conversation: recording is prohibited unless all parties give prior written consent, unless verbal notice is given and recorded at the start of the call, or unless an automatic recurring tone-warning signal is used during the call. A violation exposes the recording party to civil damages, costs, and attorney's fees.

- **Improper Recordings or Sharing Remain Prohibited.** The virtual monitoring and visitation laws do not authorize hidden, voyeuristic, intimate, malicious, or otherwise improper recordings, or the improper posting, distribution, or disclosure of recordings.

Separate Connecticut laws may apply when the provider, as an employer, uses cameras or other electronic monitoring that may capture employees. For example, Conn. Gen. Stat. § 31-48d requires employers that engage in electronic monitoring to give prior written notice to affected employees and post a conspicuous notice concerning the types of monitoring. The statute excludes collection of information "for security purposes in common areas of the employer's premises which are held out for use by the public," so the need for employee notice turns on whether the MRC hallway cameras fall within that exception. Public Act No. 26-73, effective October 1, 2026, also requires notice of the specific locations where monitoring may occur. In addition, Conn. Gen. Stat. § 31-48b separately prohibits employers from using electronic surveillance devices to record or monitor employees in areas designed for employee health or personal comfort or for safeguarding possessions, such as rest rooms, locker rooms, or lounges.

A related issue may arise where a resident or family member independently hires a private-duty aide or other worker. In that circumstance, the resident or family member (not the provider) may have separate obligations as an employer or principal depending on the facts. For example, if resident-owned cameras or other electronic monitoring capture a privately hired aide, the resident

or family member should consider whether employee-notice or other privacy and recording laws apply. This is distinct from the provider's obligations as the facility operator or employer, but may be relevant when the provider is asked to approve, respond to, or set rules for resident-owned monitoring technology.

## V. ACTION STEPS FOR PROVIDERS

Resident use of cameras, video doorbells, audio features, and other monitoring technology depends on the provider type and on the location and function of the device. Nursing homes and, beginning October 1, 2026, RCHs have specific statutory frameworks for resident-owned virtual monitoring technology. MRCs do not have a comparable monitoring-specific statute. They may regulate resident recording technology through leases, residency agreements, and community rules, especially where the device records common areas or other residents, staff, or visitors. Restrictions on technology used solely inside a resident's private unit should be more limited and tied to legitimate privacy, safety, access, or operational concerns.

- **Review and update policies.** Nursing homes should confirm that their virtual monitoring and visitation policies comply with Conn. Gen. Stat. § 19a-550b, including the changes effective October 1, 2026. RCHs should consider developing virtual monitoring policies before October 1, 2026. MRCs should review residency agreements and community rules and consider addressing cameras, video doorbells, audio recording, and recordings in common areas.

- **Use setting-specific forms.** Nursing homes should continue to use the Long-Term Care Ombudsman forms that contain the required statutory elements. RCHs should prepare forms that track PA 26-28's notice, roommate consent, withdrawal of consent, resident responsibility, and waiver requirements unless and until RCH-specific Ombudsman forms are issued.

- **Address video doorbells and common-area recording directly.** MRCs, in particular, should state clearly whether resident-installed video doorbells or similar devices are prohibited or limited when they record hallways, corridors, entrances, or other shared spaces.

- **Train staff on what to do when a device is identified.** Staff should know who to notify, what documentation to request, how to confirm whether roommate consent is required, and when to escalate privacy or safety concerns.

- **Apply restrictions consistently.** Any limits on recording devices should be written, communicated to residents and representatives, and applied consistently to reduce disputes and enforcement risk.

Appendix B

***MODEL FORM***

Instructions: The MRC Bill of Rights must be posted in a prominent place in the MRC and provided and explained to each resident at the time the resident enters into a residency agreement at the MRC.

**INSERT MANAGED RESIDENTIAL COMMUNITY NAME HERE**

# MANAGED RESIDENTIAL COMMUNITY RESIDENT'S BILL OF RIGHTS

Name of Resident: _____

As a resident of a Managed Residential Community, you have the right to:

- Live in a clean, safe and habitable private residential unit.

- Be treated with consideration, respect and due recognition of personal dignity, individuality and the need for privacy.

- Privacy within your private residential unit, subject to our rules that are reasonably designed to promote your health, safety and welfare.

- Retain and use your own personal property within your private residential unit so as to maintain individuality and personal dignity provided the use of personal property does not infringe on the rights of other residents or threaten the health, safety and welfare of other residents.

- Treat your residential unit as your home and have no fewer rights than any other resident of the state, including but not limited to, (A) associating and communicating privately with persons of your choice, (B) purchasing and using technology of your choice, including, but not limited to, technology that may facilitate virtual visitation with family and other persons, provided operation and use of such technology shall not violate any individual's right to privacy under state or federal law, and (C) engaging in other private

communications, including receiving and sending unopened correspondence and telephone access.

- Freedom to participate in and benefit from community services and activities so as to achieve the highest possible level of independence, autonomy and interaction within the community.

- Directly engage or contract with licensed health care professionals and providers of your choice to obtain necessary health care services in your private residential unit, or such other space as we may make available to residents for such purposes.

- Manage your own financial affairs.

- Exercise civil and religious liberties.

- Present grievances and recommend changes in policies, procedures and services to us, government officials or any other person without restraint, interference, coercion, discrimination or reprisal from us, including access to representatives of the Department of Public Health at:

  Connecticut Department of Public Health
  Facility Licensing and Investigations Section
  410 Capitol Ave., MS# 12 HSR
  Hartford, CT 06134-0308
  Phone: (860) 509-7400
  Fax: (860) 730-8390
  Email: dph.fliscomplaint@ct.gov
  https://dphflisevents.ct.gov/Complaints

  or the Office of the Long-Term Care Ombudsman at:

  Mairead Painter
  Connecticut Long-Term Care Ombudsman Program
  55 Farmington Avenue
  Hartford, Connecticut 06105-3730

Phone: (860) 424-5200
Toll Free In-State: (866) 388-1888
Fax: (860) 424-4966
E-mail: ltcop@ct.gov
https://portal.ct.gov/LTCOP

INSERT name and contact information for Regional Ombudsman (For a list of the Regional Ombudsman and the towns they serve, click here).

- Report suspected abuse, neglect exploitation or abandonment of an elderly person, or that an elderly person may be in need of protective services, to the Department of Social Services at:

  Connecticut Department of Social Services
  Protective Services for the Elderly Program
  During Business Hours: 1-888-385-4225
  After Hour Emergencies: 2-1-1

- Upon request, obtain the name of the service coordinator or any other persons responsible for resident care or the coordination of resident care.

- Confidential treatment of all records and communications to the extent required by state and federal law.

- Have all reasonable requests responded to promptly and adequately within our capacity and with due consideration given to the rights of other residents.

- Be fully advised of the relationship that the managed residential community has with any assisted living services agency, health care facility or educational institution to the extent that such relationship relates to resident medical care or treatment and to receive an explanation about the relationship.

- Receive a copy of our rules or regulations.

- Privacy when receiving medical treatment or other services within the capacity of the managed residential community.

- Refuse care and treatment and participate in the planning for the care and services you need or receive, provided the refusal of care and treatment may preclude you from being able to continue to reside in the managed residential community.

- All rights and privileges afforded to tenants under Title 47a of the Connecticut General Statutes.

*Revised August 2026*

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS RESIDENTS' BILL OF RIGHTS AND THAT IT HAS BEEN EXPLAINED TO ME.

_____
Signature

_____
Date

If signed by someone other than Resident:

Name of person signing on behalf of
Resident

_____
Print Name

_____ _____
Signature Relationship to Resident

_____
Date

Appendix C

**Connecticut Public Act 26-13, Section 4:**
**Notice of Medical Record Retention and Access Rights Required by January 1, 2027**

Section 4 of Connecticut Public Act No. 26-13 requires that, not later than January 1, 2027, each health care provider provide written notice to each patient at the time of initial intake regarding (1) the laws governing how long the provider must maintain patient medical records and (2) how the patient may request copies of those records.

There is no required form for this notice. Providers may choose the format that works best operationally, including incorporating the notice into existing intake materials such as the HIPAA Notice of Privacy Practices.

Below is a summary of selected Connecticut record retention requirements that may be relevant to long-term care and related providers. Because retention requirements can vary depending on the provider type, licensure category, and setting, providers should confirm which rule applies to their operations before finalizing a notice.

- **Nursing Homes**: Patient medical records must be retained for not less than 7 years following the date of the patient's discharge or, in the case of a patient who dies at the facility, not less than 7 years following the date of death (Conn. Gen. Stat. § 19a-522b(a)).

- **Home Health Care Agencies**: Clinical records must be retained for at least 7 years from date of last service to the patient (Regs. Conn. State Agencies § 19-13-D75(a)(2)).

- **Hospice**: Record retention requirements for hospice providers in Connecticut depend on the regulatory framework under which services are provided.
    - **Free-standing hospice facilities and distinct hospice units**: Medical records must be retained for not less than 25 years after discharge (Regs. Conn. State Agencies § 19a-495-5b(d)(6)).
    - **Hospice inpatient facilities**: Medical records must be retained for not less than 7 years after discharge (Regs. Conn. State Agencies § 19a-495-6d(5)).
    - **Hospice services provided through a licensed home health care agency**: Medical records must be retained for at least 7 years from the date of last service (Regs. Conn. State Agencies § 19-13-D75(a)(2)).

- **Assisted Living Services Agencies**: Client service records must be retained for at least 7 years following death or discharge of the client from the assisted living services agency (Regs. Conn. State Agencies § 19-13-D105(k)(7)).

- **Residential Care Homes**: Connecticut statutes and regulations do not clearly prescribe a specific, standalone medical record retention period for residential care homes in the same manner as for certain other provider types. Accordingly, in the absence of a provider-specific requirement, these providers generally rely on the baseline medical record retention standard under Regs. Conn. State Agencies § 19a-14-42 which requires retention for at least 7 years from the last date of treatment, or 3 years after the patient's death, whichever is later.

Where more than one requirement applies, records are maintained for the longest applicable period. Records may also be retained longer as required for legal, regulatory, or audit purposes. If a claim of malpractice, unprofessional conduct, or negligence with respect to a particular patient has been made, or if litigation has been commenced, then all records for that patient must be retained until the matter is resolved.

While the manner in which the patient may request copies of the patient's medical records from the provider may differ from provider to provider, note that there are state and federal limitations on what patients can be charged for copies of their records.

- Connecticut law permits a provider to charge up to $0.65 per page for copies of medical records, which includes copying and administrative costs, plus reasonable postage or media costs, if applicable (Conn. Gen. Stat. §§ 20-7c and 19a-490b). Certain records must be provided at no charge, including when records are requested in connection with Social Security claims or Veterans' benefits claims (Conn. Gen. Stat. § 20-7c).

- Federal HIPAA law applies when records are requested by the patient or the patient's personal representative. Fees must be reasonable and cost-based and may include only labor for copying (including scanning); supplies (paper, electronic media); and postage. Fees may be lower than the Connecticut per-page amount and must not exceed actual cost (45 CFR § 164.524(c)(4)).

When both state and federal law apply, the provider complies with the requirement that results in the lower permissible fee.

Attached is a template notice that you can tailor for your organization. If you have any questions or concerns, please contact Jody Erdfarb at JErdfarb@wiggin.com.

# Notice of Medical Record Retention, Access, and Copying Fees

This notice explains how long we keep your medical records, how you can request them, and what fees may apply.

## How Long We Keep Your Medical Records

We keep your medical records for the period required by law. The length of time depends on the type of services you received:

- **Assisted Living Services**: Medical records are kept for at least 7 years following death or discharge from the assisted living services agency.
- **Home Health Care Services**: Medical records are kept for at least 7 years after your last date of service.
- **Hospice Services**: The required retention period depends on how hospice services are provided:
    - Free-standing hospice facilities and distinct hospice units must keep records for at least 25 years after discharge.
    - Hospice inpatient facilities must keep records for at least 7 years after discharge.
- **Residential Care Homes**: Medical records are generally kept for at least 7 years after your last date of treatment, or 3 years after death, unless a longer period is required.
- **Nursing Homes (Chronic and Convalescent Nursing Homes)**: Medical records are kept for at least 7 years after discharge, or 7 years after death if the patient dies while in the facility.

In some situations, records may be kept longer if required for legal, billing, audit, or regulatory purposes.

## How to Request Your Medical Records

You or a person authorized to act on your behalf may request a copy of your medical records. To request your records, please contact:
**[Insert name/department]**
**[Insert address / email / phone]**

Your request should include:

- Your name and date of birth
- A description of the records you are requesting

- Where you would like the records sent
- Your signature (or appropriate authorization)

## Fees for Copies of Medical Records

Under Connecticut law, the charge for copies is no more than $0.65 per page, which includes most associated costs. If records are mailed, postage may also apply. We will not charge a fee if the records are needed to support a Social Security claim or appeal or a veterans' benefits claim or appeal. When federal privacy laws apply, any fee will be limited to a reasonable, cost-based amount.

## Questions

If you have any questions about this notice or how to request your records, please contact:
**[Insert contact information]**

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Appendix D

**[Per Public Act No. 26-84, each tenant should receive the following notice at least twenty-four hours prior to any scheduled maintenance of an elevator or no later than twenty-four hours after an elevator is first reported as being inoperable and has not yet been restored to service]**

**[COMMUNITY NAME/LETTERHEAD]**

**NOTICE OF ELEVATOR OUTAGE**

**Date of Notice:** [DATE]

**To:** Residents of [BUILDING NAME/ADDRESS served by affected elevator]

**Re**: **Inoperable Elevator – [Elevator Identification/Location]**

Dear Resident,

We wish to keep you informed about an issue with the elevator in your building and let you know what we are doing to resolve it as quickly as possible.

1. **Elevator Affected:** The elevator located at [LOCATION/DESCRIPTION] was reported inoperable on [DATE/TIME] and has not yet been restored to service.
2. **Cause of Inoperability:** [if known, describe cause] [if not known: "The cause of the outage has not yet been determined. This notice will be updated once that information is available"]
3. **Estimated Time for Restoration:** [if known: state estimated date/time] [if not known: "An estimated restoration time has not yet been determined. This notice will be updated once that information is available."]
4. **Repair Status Contact:** For current information concerning the status of this repair, please contact:
   Name: [CONTACT NAME]
   Title: [TITLE]
   Phone: [PHONE NUMBER]
   Email: [EMAIL ADDRESS]
5. **Local Building Official Contact:** To report a violation of Section 2 of Public Act No. 26-84 or applicable building or housing codes, please contact the local building official for [MUNICIPALITY]:
   Name: [NAME]
   Office: [OFFICE/DEPARTMENT NAME]
   Phone: [PHONE NUMBER]
   Email: [EMAIL ADDRESS]

**Emergency and Access Reminder:** If this elevator is not working and it is an emergency, dial 911. If it is not an emergency and you do not have access to another working elevator for at least forty-eight (48) consecutive hours, please call [MUNICIPALITY] at [PHONE NUMBER].

We apologize for any inconvenience this outage may cause and are working to restore elevator service as quickly as possible. Additional updates will be provided as new information becomes available.

Sincerely,

[NAME]
[TITLE]

*This notice is being provided to you pursuant to Section 2(b)(3) of Public Act No. 26-84.*

[COMMUNITY NAME]
[CONTACT INFORMATION]

*This notice is being provided to you pursuant to Section 2(b)(3) of Public Act No. 26-84.*

If this elevator is not working and it is an emergency, dial 911. If it is not an emergency and you do not have access to another working elevator for at least forty-eight (48) consecutive hours, call [APPLICABLE MUNICIPALITY] at [MUNICIPALITY PHONE NUMBER].

Si este ascensor no está funcionando y se trata de una emergencia, llame al 911. Si no es una emergencia y no tiene acceso a otro ascensor en funcionamiento durante al menos cuarenta y ocho (48) horas consecutivas, llame a [APPLICABLE MUNICIPALITY] al [MUNICIPALITY PHONE NUMBER].