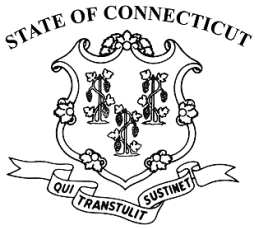

Substitute Senate Bill No. 986

Public Act No. 23-147

AN ACT PROTECTING MATERNAL HEALTH.

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

Section 1. Section 19a-490 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2024*):

As used in this chapter, unless the context otherwise requires:

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

operated or maintained by any state agency, except Whiting Forensic Hospital and the hospital and psychiatric residential treatment facility units of the Albert J. Solnit Children's Center;

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

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

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

(e) "Home health aide agency" means a public or private organization, except a home health care agency, which provides in the patient's home or a substantially equivalent environment supportive services which may include, but are not limited to, assistance with personal hygiene, dressing, feeding and incidental household tasks essential to achieving adequate household and family management.

Such supportive services shall be provided under the supervision of a registered nurse and, if such nurse determines appropriate, shall be provided by a social worker, physical therapist, speech therapist or occupational therapist. Such supervision may be provided directly or through contract;

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

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

(h) "Clinical laboratory" means any facility or other area used for microbiological, serological, chemical, hematological, immunohematological, biophysical, cytological, pathological or other examinations of human body fluids, secretions, excretions or excised or exfoliated tissues for the purpose of providing information for the (1) diagnosis, prevention or treatment of any human disease or impairment, (2) assessment of human health, or (3) assessment of the presence of drugs, poisons or other toxicological substances;

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

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

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

(l) "Assisted living services agency" means an agency that provides, among other things, nursing services and assistance with activities of daily living to a population that is chronic and stable and may have a dementia special care unit or program as defined in section 19a-562;

(m) "Outpatient clinic" means an organization operated by a municipality or a corporation, other than a hospital, that provides (1) ambulatory medical care, including preventive and health promotion services, (2) dental care, or (3) mental health services in conjunction with medical or dental care for the purpose of diagnosing or treating a health condition that does not require the patient's overnight care;

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

(o) "Nursing home" or "nursing home facility" means (1) any chronic and convalescent nursing home or any rest home with nursing supervision that provides nursing supervision under a medical director twenty-four hours per day, or (2) any chronic and convalescent nursing home that provides skilled nursing care under medical supervision and direction to carry out nonsurgical treatment and dietary procedures for chronic diseases, convalescent stages, acute diseases or injuries;

(p) "Outpatient dialysis unit" means (1) an out-of-hospital out-patient

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

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

(r) "Psychiatric residential treatment facility" means a nonhospital facility with a provider agreement with the Department of Social Services to provide inpatient services to Medicaid-eligible individuals under the age of twenty-one; **[**and**]**

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

(t) "Birth center" means a freestanding facility that is licensed by the department (1) to provide perinatal, labor, delivery and postpartum care during and immediately after delivery to persons presenting with a low-risk pregnancy and healthy newborns for a period typically less than twenty-four hours, and (2) that is not a hospital licensed pursuant to the provisions of this chapter, or attached to or located in such a hospital. For the purposes of this subsection, "low-risk pregnancy" means an uncomplicated, singleton pregnancy that has vertex presentation and is at low risk for developing complications during labor and birth, as determined by an evaluation and examination conducted by a licensed health care provider acting within the scope of such provider's practice.

Sec. 2. (NEW) (*Effective October 1, 2023*) (a) On and after January 1,

2024, no person, entity, firm, partnership, corporation, limited liability company or association shall establish, conduct, operate or maintain a birth center, as defined in section 19a-490 of the general statutes, as amended by this act, in this state without obtaining a license pursuant to the provisions of this section. Except in the case of an emergency, an outpatient clinic shall not offer any birth center services as part of its ambulatory medical services without being licensed as a birth center. For the purposes of this subsection, "birth center services" means perinatal, labor, delivery and postpartum care during and immediately after delivery to persons presenting with a low-risk pregnancy and healthy newborns for a period typically less than twenty-four hours and "low-risk pregnancy" has the same meaning as provided in subsection (t) of section 19a-490 of the general statutes, as amended by this act.

(b) Each birth center shall be accredited by the Commission for the Accreditation of Birth Centers on or before the effective date of its licensure and maintain such accreditation during the time it is licensed. If a birth center loses its accreditation, the birth center shall immediately notify the Commissioner of Public Health and cease providing birth center services to patients until authorized by the commissioner to reinstate such services.

(c) (1) Each birth center shall have a written plan to obtain services for its patients from a hospital, licensed pursuant to chapter 368v of the general statutes, to provide services in the event of an emergency or other conditions that pose a risk to the health of a patient that require transfer of the patient to a hospital. Before issuing a license pursuant to this section, the commissioner shall review and approve the information submitted by the birth center to the Commission for the Accreditation of Birth Centers, including, but not limited to, (A) information relating to the birth center's plan for ongoing risk assessment and adherence to patient eligibility criteria, as determined by the Commission for the Accreditation of Birth Centers, during the delivery of birth center

services to a patient, and (B) information relating to the birth center's policies and procedures for the prenatal, intrapartum or postpartum transfer of a patient in the event that such patient no longer meets such patient eligibility criteria.

(2) If a patient receiving birth center services no longer presents with a low-risk pregnancy, as defined in section 19a-490 of the general statutes, as amended by this act, or otherwise fails to meet the patient eligibility criteria described subparagraph (A) of subdivision (1) of this subsection, the birth center providing such services shall ensure the patient's care is transferred to a licensed health care provider capable of providing the appropriate level of obstetrical care for the patient.

(d) Each hospital licensed pursuant to chapter 368v of the general statutes that maintains an emergency department, other than a children's hospital, shall work cooperatively with birth centers to coordinate the care of patients who may require services in the event of an emergency or other conditions that pose a risk to the health of a patient that require transfer of the patient to a hospital. Each children's hospital that maintains an emergency department shall work cooperatively with birth centers to coordinate the care of neonatal patients who may require services in the event of an emergency or other conditions that pose a risk to the health of a patient that require transfer of the patient to a children's hospital.

(e) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section and section 19a-495 of the general statutes. The commissioner may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulations, provided notice of intent to adopt regulations is published on the eRegulations system not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final

regulations are adopted. The regulations and policies and procedures shall include, but need not be limited to, provisions regarding the administration of the facility, staffing requirements, infection control protocols, physical plant requirements, accommodation of the participation of support persons of the patient's choice, limitations on the provision of anesthesia and surgical procedures, operating procedures for determining risk status of patients at admission and during labor, reportable events, medical records, pharmaceutical services, laundry services, requirements for professional and medical liability insurance for the facility and health care providers and emergency planning.

Sec. 3. Subsection (c) of section 19a-491 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2024*):

(c) **[**Notwithstanding any regulation, the**]** The Commissioner of Public Health shall charge the following fees for the biennial licensing and inspection of the following institutions: (1) Chronic and convalescent nursing homes, per site, four hundred forty dollars; (2) chronic and convalescent nursing homes, per bed, five dollars; (3) rest homes with nursing supervision, per site, four hundred forty dollars; (4) rest homes with nursing supervision, per bed, five dollars; (5) outpatient dialysis units and outpatient surgical facilities, six hundred twenty-five dollars; (6) mental health residential facilities, per site, three hundred seventy-five dollars; (7) mental health residential facilities, per bed, five dollars; (8) hospitals, per site, nine hundred forty dollars; (9) hospitals, per bed, seven dollars and fifty cents; (10) nonstate agency educational institutions, per infirmary, one hundred fifty dollars; (11) nonstate agency educational institutions, per infirmary bed, twenty-five dollars; (12) home health care agencies, except certified home health care agencies described in subsection (d) of this section, per agency, three hundred dollars; (13) home health care agencies, hospice agencies or

home health aide agencies, except certified home health care agencies, hospice agencies or home health aide agencies described in subsection (d) of this section, per satellite patient service office, one hundred dollars; (14) assisted living services agencies, except such agencies participating in the congregate housing facility pilot program described in section 8-119n, per site, five hundred dollars; (15) short-term hospitals special hospice, per site, nine hundred forty dollars; (16) short-term hospitals special hospice, per bed, seven dollars and fifty cents; (17) hospice inpatient facility, per site, four hundred forty dollars; **[**and**]** (18) hospice inpatient facility, per bed, five dollars; and (19) birth centers, per site, nine hundred forty dollars and, per bed, seven dollars and fifty cents.

Sec. 4. Section 20-86b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2024*):

Nurse-midwives shall practice within a health care system or birth center and have clinical relationships with obstetrician-gynecologists that provide for consultation, collaborative management or referral, as indicated by the health status of the patient. Nurse-midwifery care shall be consistent with the standards of care established by the Accreditation Commission for Midwifery Education. Each nurse-midwife shall provide each patient with information regarding, or referral to, other providers and services upon request of the patient or when the care required by the patient is not within the midwife's scope of practice. Each nurse-midwife shall sign the birth certificate of each infant delivered by the nurse-midwife. If an infant is born alive and then dies within the twenty-four-hour period after birth, the nurse-midwife may make the actual determination and pronouncement of death provided: (1) The death is an anticipated death; (2) the nurse-midwife attests to such pronouncement on the certificate of death; and (3) the nurse-midwife or a physician licensed pursuant to chapter 370 certifies the certificate of death not later than twenty-four hours after such

pronouncement. In a case of fetal death, as described in section 7-60, the nurse-midwife who delivered the fetus may make the actual determination of fetal death and certify the date of delivery and that the fetus was born dead.

Sec. 5. Subsection (a) of section 19a-613 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) The Health Systems Planning Unit may employ the most effective and practical means necessary to fulfill the purposes of this chapter, which may include, but need not be limited to:

(1) Collecting patient-level outpatient data from health care facilities, **[**or institutions,**]** as defined in section 19a-630, and birth centers, as defined in section 19a-490, as amended by this act;

(2) Establishing a cooperative data collection effort, across public and private sectors, to assure that adequate health care personnel demographics are readily available; and

(3) Performing the duties and functions as enumerated in subsection (b) of this section.

Sec. 6. Subsection (b) of section 19a-127n of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(b) On and after October 1, **[**2002**]** 2023, a hospital or birth center, as such terms are defined in section 19a-490, as amended by this act, or outpatient surgical facility, as defined in section 19a-493b, shall report adverse events to the Department of Public Health on a form prescribed by the commissioner as follows: (1) A written report and the status of any corrective steps shall be submitted not later than seven days after the date on which the adverse event occurred; and (2) a corrective action

plan shall be filed not later than thirty days after the date on which the adverse event occurred. Emergent reports, as defined in the regulations adopted pursuant to subsection (c) of this section, shall be made to the department immediately. Failure to implement a corrective action plan may result in disciplinary action by the commissioner, pursuant to section 19a-494.

Sec. 7. Section 19a-505 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) No person shall keep a maternity hospital or lying-in place unless such person has previously obtained a license therefor, issued by the Department of Public Health. Each such license shall be valid for a term of two years and may be revoked by the Department of Public Health upon proof that the institution for which such license was issued is being improperly conducted or for the violation of any of the provisions of this section or of the Public Health Code, or on the basis of lack of demonstrable need, provided the licensee shall be given a reasonable opportunity to be heard in reference to such proposed revocation.

(b) Within six hours after the departure, removal or withdrawal of any child born at such maternity hospital or lying-in place, the keeper thereof shall make a record of such departure, removal or withdrawal of such child, the names and residences of the persons who took such child or its body and the place to which it was taken and where it was left, which record shall be produced by the keeper or licensee of such hospital or lying-in place, for inspection by and upon the demand of any person authorized to make such inspection by the Department of Public Health or the council. Each keeper of any such hospital or lying-in place, and his servants and agents, shall permit any person so authorized to enter such hospital or lying-in place and inspect such hospital or lying-in place and all of its appurtenances, for the purpose of detecting any improper treatment of any child or any improper management or conduct in such hospital or lying-in place or its appurtenances. Each

person so authorized may remove any article which he may think presents evidence of any crime being committed therein and deliver the same to the appropriate law enforcement official to be disposed of according to law. Any person who violates any provision of this section shall be fined not more than two hundred dollars or imprisoned not more than six months or both.

(c) On and after January 1, 2024, the Commissioner of Public Health shall not grant or renew a maternity hospital license pursuant to this section.

Sec. 8. Subsection (b) of section 19a-638 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2024*):

(b) A certificate of need shall not be required for:

(1) Health care facilities owned and operated by the federal government;

(2) The establishment of offices by a licensed private practitioner, whether for individual or group practice, except when a certificate of need is required in accordance with the requirements of section 19a-493b or subdivision (3), (10) or (11) of subsection (a) of this section;

(3) A health care facility operated by a religious group that exclusively relies upon spiritual means through prayer for healing;

(4) Residential care homes, as defined in subsection (c) of section 19a-490, as amended by this act, and nursing homes and rest homes, as defined in subsection (o) of section 19a-490, as amended by this act;

(5) An assisted living services agency, as defined in section 19a-490, as amended by this act;

(6) Home health agencies, as defined in section 19a-490, as amended

by this act;

(7) Hospice services, as described in section 19a-122b;

(8) Outpatient rehabilitation facilities;

(9) Outpatient chronic dialysis services;

(10) Transplant services;

(11) Free clinics, as defined in section 19a-630;

(12) School-based health centers and expanded school health sites, as such terms are defined in section 19a-6r, community health centers, as defined in section 19a-490a, not-for-profit outpatient clinics licensed in accordance with the provisions of chapter 368v and federally qualified health centers;

(13) A program licensed or funded by the Department of Children and Families, provided such program is not a psychiatric residential treatment facility;

(14) Any nonprofit facility, institution or provider that has a contract with, or is certified or licensed to provide a service for, a state agency or department for a service that would otherwise require a certificate of need. The provisions of this subdivision shall not apply to a short-term acute care general hospital or children's hospital, or a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended;

(15) A health care facility operated by a nonprofit educational institution exclusively for students, faculty and staff of such institution and their dependents;

(16) An outpatient clinic or program operated exclusively by or

contracted to be operated exclusively by a municipality, municipal agency, municipal board of education or a health district, as described in section 19a-241;

(17) A residential facility for persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disabilities;

(18) Replacement of existing imaging equipment if such equipment was acquired through certificate of need approval or a certificate of need determination, provided a health care facility, provider, physician or person notifies the unit of the date on which the equipment is replaced and the disposition of the replaced equipment;

(19) Acquisition of cone-beam dental imaging equipment that is to be used exclusively by a dentist licensed pursuant to chapter 379;

(20) The partial or total elimination of services provided by an outpatient surgical facility, as defined in section 19a-493b, except as provided in subdivision (6) of subsection (a) of this section and section 19a-639e;

(21) The termination of services for which the Department of Public Health has requested the facility to relinquish its license;

(22) Acquisition of any equipment by any person that is to be used exclusively for scientific research that is not conducted on humans; **[**or**]**

(23) On or before June 30, 2026, an increase in the licensed bed capacity of a mental health facility, provided (A) the mental health facility demonstrates to the unit, in a form and manner prescribed by the unit, that it accepts reimbursement for any covered benefit provided to a covered individual under: (i) An individual or group health insurance policy providing coverage of the type specified in

subdivisions (1), (2), (4), (11) and (12) of section 38a-469; (ii) a self-insured employee welfare benefit plan established pursuant to the federal Employee Retirement Income Security Act of 1974, as amended from time to time; or (iii) HUSKY Health, as defined in section 17b-290, and (B) if the mental health facility does not accept or stops accepting reimbursement for any covered benefit provided to a covered individual under a policy, plan or program described in clause (i), (ii) or (iii) of subparagraph (A) of this subdivision, a certificate of need for such increase in the licensed bed capacity shall be required; or

(24) On or before June 30, 2028, a birth center, as defined in section 19a-490, as amended by this act, that is enrolled as a provider in the Connecticut medical assistance program, as defined in section 17b-245g.

Sec. 9. (*Effective October 1, 2023*) The executive director of the Office of Health Strategy, in consultation with the Commissioner of Public Health, shall, within available appropriations, study whether the certificate of need exemption for birth centers described in subdivision (24) of subsection (b) of section 19a-638 of the general statutes, as amended by this act, should be extended. Pursuant to such study, the executive director shall collect data from birth centers in the state concerning (1) the number of deliveries performed at each birth center and the number of patient transfers or referrals to other settings of care, including the reason for such transfers and referrals, (2) the number and percentages of patients who are self-pay, covered by commercial insurance and covered by a government payer program, including, but not limited to, the Connecticut medical assistance program, as defined in section 17b-245g of the general statutes, (3) patient demographic information, including the race, ethnicity and preferred language of patients, (4) geographic locations of birth centers and catchment areas, (5) financial assistance and uncompensated care provided by each birth center, and (6) any other information deemed necessary by the executive director. Not later than July 1, 2027, the executive director shall report,

in accordance with the provisions of section 11-4a of the general statutes, regarding such study to the joint standing committee of the General Assembly having cognizance of matters relating to public health.

Sec. 10. (NEW) (*Effective October 1, 2023*) (a) As used in this section and section 11 of this act, "infant death" means the death of a child that occurs between birth and one year of age.

(b) There is established, within the Department of Public Health, an infant mortality review program. The purpose of the program shall be to review medical records and other relevant data related to infant deaths, including, but not limited to, information collected from death and birth records, and medical records from health care providers and health care facilities for the purposes of making recommendations to reduce health care disparities and identify gaps in or problems with the delivery of care or services to reduce infant deaths.

(c) All health care providers, health care facilities and pharmacies shall provide the Commissioner of Public Health, or the commissioner's designee, with access to all medical and other records associated with an infant death case under review by the program, including, but not limited to, prenatal care records, upon the request of the commissioner.

(d) A person who completes a death certificate pursuant to section 7-62b or section 19a-409 of the general statutes for an infant death shall report such death to the department in a form and manner prescribed by the commissioner.

(e) Notwithstanding any provision of the general statutes, the commissioner shall notify the child fatality review panel, established pursuant to section 46a-13*l* of the general statutes, of an infant death if, pursuant to a review performed by the infant mortality review program, the commissioner determines that such infant death occurred in out-of-home care or was due to unexpected or unexplained causes.

(f) All information obtained by the commissioner, or the commissioner's designee, for the infant mortality review program shall be confidential pursuant to section 19a-25 of the general statutes, as amended by this act.

(g) Notwithstanding any provision of the general statutes, the commissioner, or the commissioner's designee may provide the infant mortality review committee, established pursuant to section 11 of this act, with information as is necessary, in the commissioner's discretion, for the committee to make recommendations regarding the prevention of infant deaths.

(h) The provisions of this section and section 11 of this act shall not be construed to limit or alter the authority of the Office of the Child Advocate or the child fatality review panel, established pursuant to section 46a-13*l* of the general statutes, to investigate or make recommendations regarding a child's death pursuant to the provisions of said section.

Sec. 11. (NEW) (*Effective October 1, 2023*) (a) There is established an infant mortality review committee within the department to conduct a comprehensive, multidisciplinary review of infant deaths for purposes of reducing health care disparities, identifying factors associated with infant deaths and making recommendations to reduce infant deaths.

(b) The cochairpersons of the infant mortality review committee shall be the Commissioner of Public Health, or the commissioner's designee, and a representative designated by the Connecticut chapter of the American Academy of Pediatrics. The cochairpersons shall convene a meeting of the infant mortality review committee upon the request of the Commissioner of Public Health.

(c) The infant mortality review committee may include, but need not be limited to, any of the following members, as needed, depending on

the infant death case being reviewed:

(1) A physician licensed pursuant to chapter 370 of the general statutes, who specializes in obstetrics and gynecology, designated by the Connecticut Chapter of the American College of Obstetrics and Gynecology;

(2) A community health worker, designated by the Commission on Women, Children, Seniors, Equity and Opportunity;

(3) A pediatric nurse licensed pursuant to chapter 378 of the general statutes, designated by the Connecticut Nurses Association;

(4) A clinical social worker licensed pursuant to chapter 383b of the general statutes, designated by the Connecticut Chapter of the National Association of Social Workers;

(5) The Chief Medical Examiner, or the Chief Medical Examiner's designee;

(6) A member of the Connecticut Hospital Association representing a pediatric facility;

(7) A representative of The University of Connecticut-sponsored Health Disparities Institute;

(8) A physician licensed pursuant to chapter 370 of the general statutes, who practices neonatology, designated by the Connecticut Medical Society;

(9) A physician assistant licensed pursuant to chapter 370 of the general statutes or advanced practice registered nurse licensed pursuant to chapter 378 of the general statutes, designated by an association representing physician assistants or advanced practice registered nurses in the state;

(10) The Child Advocate, or the Child Advocate's designee;

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

(12) The Commissioner of Children and Families, or the commissioner's designee;

(13) The Commissioner of Early Childhood, or the commissioner's designee;

(14) The Commissioner of Mental Health and Addiction Services, or the commissioner's designee; and

(15) Any additional member the cochairpersons determine would be beneficial to serve as a member of the committee.

(d) For any infant mortality review, the committee may consult with relevant experts to evaluate the information and findings obtained from the department pursuant to section 10 of this act and make recommendations regarding the prevention of infant deaths.

(e) The infant mortality review committee shall include available infant death reports and recommendations produced by the child fatality review panel, established pursuant to section 46a-13*l* of the general statutes, in its review of infant deaths for the purposes of making recommendations to reduce health care disparities and identify gaps in or problems with the delivery of care or services to reduce infant deaths.

(f) Not later than ninety days after completing an infant mortality review, the committee shall, in consultation with the Office of the Child Advocate, report to the Commissioner of Public Health the recommendations and findings of the committee in a manner that complies with section 19a-25 of the general statutes, as amended by this

act.

(g) All information provided by the department to the infant mortality review committee or provided to any expert consulted by the committee shall be subject to the provisions of section 19a-25 of the general statutes, as amended by this act.

Sec. 12. Subsection (a) of section 19a-25 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) All information, records of interviews, written reports, statements, notes, memoranda or other data, including personal data as defined in subdivision (9) of section 4-190, procured by: (1) The Department of Public Health, by staff committees of facilities accredited by the Department of Public Health, **[**or**]** the maternity mortality review committee, established pursuant to section 19a-59i, or the infant mortality review committee, established pursuant to section 11 of this act, in connection with studies of morbidity and mortality conducted by the Department of Public Health, such staff committees, **[**or**]** the maternal mortality review committee or the infant mortality review committee, or carried on by said department, such staff committees or the maternal mortality review committee jointly with other persons, agencies or organizations, (2) the directors of health of towns, cities or boroughs or the Department of Public Health pursuant to section 19a-215, or (3) the Department of Public Health or such other persons, agencies or organizations, for the purpose of reducing the morbidity or mortality from any cause or condition, shall be confidential and shall be used solely for the purposes of medical or scientific research and, for information obtained pursuant to section 19a-215, disease prevention and control by the local director of health and the Department of Public Health and reducing the morbidity or mortality from any cause or condition. Such information, records, reports, statements, notes, memoranda or other data shall not be admissible as evidence in any

action of any kind in any court or before any other tribunal, board, agency or person, nor shall it be exhibited or its contents disclosed in any way, in whole or in part, by any officer or representative of the Department of Public Health or of any such facility, by any person participating in such a research project or by any other person, except as may be necessary for the purpose of furthering the research project or public health use to which it relates.

Sec. 13. (NEW) (*Effective July 1, 2023*) (a) As used in this section:

(1) "Certified doula" means a doula that is certified by the Department of Public Health; and

(2) "Doula" means a trained, nonmedical professional who provides physical, emotional and informational support, virtually or in person, to a pregnant person and any family or friends supporting such person before, during and after birth.

(b) The Commissioner of Public Health shall, within available resources, establish a Doula Advisory Committee within the Department of Public Health. The Doula Advisory Committee shall develop recommendations for (1) requirements for certification and certification renewal of doulas, including, but not limited to, training, experience or continuing education requirements; and (2) standards for recognizing doula training program curricula that are sufficient to satisfy the requirements for doula certification.

(c) The Commissioner of Public Health, or the commissioner's designee, shall be the chairperson of the Doula Advisory Committee.

(d) The Doula Advisory Committee shall consist of the following members:

(1) Seven appointed by the Commissioner of Public Health, or the commissioner's designee, who are actively practicing as doulas in the

state;

(2) One appointed by the Commissioner of Public Health, or the commissioner's designee, who is a nurse-midwife, licensed pursuant to chapter 377 of the general statutes, who has experience working with a doula;

(3) One appointed by the Commissioner of Public Health, or the commissioner's designee, in consultation with the Connecticut Hospital Association, who shall represent an acute care hospital;

(4) One appointed by the Commissioner of Public Health, or the commissioner's designee, who shall represent an association that represents hospitals and health-related organizations in the state;

(5) One appointed by the Commissioner of Public Health, or the commissioner's designee, who shall be a licensed health care provider who specializes in obstetrics and has experience working with a doula;

(6) One appointed by the Commissioner of Public Health, or the commissioner's designee, who shall represent a community-based doula training organization;

(7) One appointed by the Commissioner of Public Health, or the commissioner's designee, who shall represent a community-based maternal and child health organization;

(8) One appointed by the Commissioner of Public Health, or the commissioner's designee, who shall have expertise in health equity;

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

(10) The Commissioner of Mental Health and Addiction Services, or the commissioner's designee; and

(11) The Commissioner of Early Childhood, or the commissioner's designee.

(e) The Doula Advisory Committee shall establish a Doula Training Program Review Committee. Such committee shall (1) conduct a continuous review of doula training programs; and (2) provide a list of approved doula training programs in the state that meet the requirements established by the Doula Advisory Committee.

Sec. 14. (NEW) (*Effective July 1, 2023*) (a) As used in this section, (1) "certified doula" means a doula who is certified by the Department of Public Health, and (2) "doula" means a trained, nonmedical professional who provides physical, emotional and informational support, virtually or in person, to a pregnant person and any family or friends supporting such person before, during and after birth.

(b) The Doula Advisory Committee, established pursuant to section 13 of this act, shall advise the Commissioner of Public Health, or the commissioner's designee, on matters relating to doula services, including, but not limited to, (1) access and promotion of education and resources for pregnant persons, and any family and friends supporting such person; (2) recommendations to improve access to doula care; and (3) furthering interagency efforts to address maternal health disparities. The committee shall decide to renew or disband the committee on an annual basis in a manner determined by the commissioner or the commissioner's designee.

(c) The Doula Training Program Review Committee, established pursuant to section 13 of this act, shall (1) conduct an ongoing review of doula education and training programs, (2) provide the commissioner, or the commissioner's designee, with a list of approved doula education and training programs, which shall include training in core doula competencies, and (3) recommend certified doula continuing education requirements to the commissioner.

(d) On and after October 1, 2023, no person shall use the title "certified doula" unless such person is certified pursuant to this section. The provisions of this section shall not be construed to prohibit a doula, who is not a certified doula, from providing doula services, provided such doula does not use the title "certified doula".

(e) Each person seeking certification to practice as a certified doula shall apply to the Department of Public Health, on forms prescribed by the commissioner, and pay an application fee of one hundred dollars. Such application shall include: (1) Proof that the applicant is eighteen years of age or older; (2) two reference letters from families or professionals with direct knowledge of the applicant's experience as a doula verifying the applicant's training or experience; and (3) (A) demonstration of the applicant's completion of a doula training program or a combination of such programs approved pursuant to subsection (c) of this section, or (B) an attestation by the applicant that such applicant has provided doula services to at least three families and training in not less than four core competencies identified by the Doula Training Program Review Committee during the five years preceding the date of the application.

(f) The commissioner may grant certification by endorsement to a doula who presents evidence satisfactory to the commissioner that the applicant is certified as a doula in another state or jurisdiction whose requirements for certification are substantially similar to those of this state for not less than two years before the date such doula submits an application for certification. No certification shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.

(g) The commissioner shall adopt continuing education requirements for certified doulas provided by the Doula Training Program Review Committee pursuant to subsection (c) of this section.

(h) Certification issued under this section may be renewed every three years. The certification shall be renewed in accordance with the provisions for renewal under section 19a-88 of the general statutes for a fee of one hundred dollars. Each certified doula applying for renewal shall provide to the commissioner evidence of completion of the continuing education requirements adopted pursuant to subsection (g) of this section.

(i) The commissioner may take any disciplinary action set forth in section 19a-17 of the general statutes against a certified doula for failure to conform to the accepted standards of the profession including, but not limited to, any of the following reasons: (1) Fraud or deceit in obtaining or seeking reinstatement of a certification to practice as a certified doula; (2) engaging in fraud or material deception in the course of professional services or activities; (3) negligent, incompetent or wrongful conduct in professional activities; (4) aiding or abetting the use of the title "certified doula" by an individual who is not certified; (5) physical, mental or emotional illness or disorder resulting in an inability to conform to the accepted standards of the profession; or (6) abuse or excessive use of drugs, including alcohol, narcotics or chemicals. The commissioner may order a certified doula to submit to a reasonable physical or mental examination if such certified doula's physical or mental capacity to practice safely is the subject of an investigation. The commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to section 19a-17 of the general statutes. The commissioner shall give notice and an opportunity to be heard on any contemplated action under section 19a-17 of the general statutes.

Sec. 15. (NEW) (*Effective July 1, 2023*) (a) As used in this section:

(1) "Certified midwife" means any individual who completes a graduate degree in midwifery and passes a national certification examination administered by the American Midwifery Certification

Board to receive the professional designation of certified midwife;

(2) "Community birth" means a planned home birth or a birth occurring at a birth center;

(3) "Direct entry midwife" means any individual trained in planned out-of-hospital births other than a nurse-midwife, which may include certified midwives, certified professional midwives, community midwives and traditional midwives; and

(4) "Licensed nurse-midwife" means any individual licensed as a nurse-midwife pursuant to chapter 377 of the general statutes.

(b) The Commissioner of Public Health shall establish a midwifery working group. The working group shall study and make recommendations concerning the advancement of choices in care for community birth and the role of direct entry midwives in addressing maternal and infant health disparities. Such study shall include, but need not be limited to:

(1) Improvements in birthing care quality and safety, including improvements addressing racial disparities in maternal and infant health outcomes;

(2) Regulation, licensure or certification of direct entry midwives not otherwise licensed to practice midwifery in the state;

(3) Regulation, licensure or certification of certified midwives not otherwise licensed to practice midwifery in the state; and

(4) Advancements of interprofessional coordination of birthing care, including community birth.

(c) The Commissioner of Public Health shall appoint members of the working group. Such members shall include, but need not be limited to, the commissioner's designee, at least six direct-entry midwives

practicing in the state, a certified nurse-midwife with experience working with direct entry midwives, a certified midwife representing an entity that certifies midwives, a doula serving communities of color, a representative of families or a community-based organization with an interest in maternity care, a representative of a community organization furthering health equity, representatives of associated maternity care professions, a representative of the state hospital association and a representative of the Department of Social Services.

(d) Not later than February 1, 2024, and annually thereafter, the midwifery working group shall report to the Commissioner of Public Health and, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health on its findings and recommendations.

(e) The midwifery working group shall select to renew or disband the group on an annual basis in a manner determined by the commissioner or the commissioner's designee.

Sec. 16. (NEW) (*Effective July 1, 2023*) (a) As used in this section, "universal nurse home visiting" means an evidence-based nurse home visiting model in which a registered nurse, licensed pursuant to chapter 378 of the general statutes, with specialized training provides services in the home to families with newborns in accordance with the provisions of this section.

(b) The Commissioner of Early Childhood, in collaboration with the Commissioners of Social Services and Public Health and the Executive Director of the Office of Health Strategy, shall, within available appropriations, develop a state-wide program to offer universal nurse home visiting services to all families with newborns residing in the state to support parental health, healthy child development and strengthen families.

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

(d) The program shall provide universal nurse home visiting services that are (1) evidence-based, and (2) designed to improve outcomes in one or more of the following areas: (A) Child safety; (B) child health and development; (C) family economic self-sufficiency; (D) maternal and parental health; (E) positive parenting; (F) reducing child mistreatment; (G) reducing family violence; (H) parent-infant bonding; and (I) any other appropriate area established, in writing, by the Commissioners of Early Childhood, Social Services and Public Health and the executive director of the Office of Health Strategy.

(e) The universal nurse home visiting services provided pursuant to the program shall (1) be voluntary and carry no negative consequences for a family that declines to participate, (2) include an evidence-based assessment of the physical, social and emotional factors affecting a family receiving such services, (3) include at least one visit during a newborn's first three months of life or other timeframe as deemed appropriate by said commissioners and executive director and that is consistent with an evidence-based model, (4) allow families to choose up to a certain number of additional visits consistent with such model, (5) include a follow-up visit no later than three months or other time frame established by such model after the last visit, and (6) provide information and referrals to address each family's identified needs. Such services may be offered in every community in the state and to all families with newborns based on the full extent of available provider capacity.

(f) The Commissioner of Social Services may seek approval of an

amendment to the state Medicaid plan or a waiver from federal law to provide coverage for universal nurse home visiting services provided pursuant to this section and in a time frame and manner to ensure that such coverage does not duplicate other applicable federal funding.

(g) The Commissioner of Early Childhood, in collaboration with the Commissioners of Social Services and Public Health and the executive director of the Office of Health Strategy, shall collect and analyze data generated by the program to assess the effectiveness of the program in meeting the goals described in subsection (d) of this section and collaborate with other state agencies to develop protocols for sharing such data, including the timely sharing of data with primary care providers that provide care to families with newborns receiving universal nurse home visiting services pursuant to the provisions of this section.

Sec. 17. Section 19a-505 of the general statutes is repealed. (*Effective July 1, 2025*)

Sec. 18. Section 40 of public act 22-58 is repealed. (*Effective July 1, 2023*)

Approved June 26, 2023